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ABSTRACT

This TIP on the best practice guidelines for the treatment of substance abuse is intended to enhance treatment providers' knowledge concerning people who have a physical or cognitive disability, in addition to their substance use disorder. The TIP is designed to educate clinicians, educators, and paraprofessionals about modifications needed in order to accommodate people in treatment for substance use disorders who have coexisting disabilities. It provides guidelines on methods of screening for disabilities and discusses treatment planning and counseling. Information on forming and maintaining linkages with other service providers is included. In making accommodations within a program for the disabled client, providers need to learn how to eliminate several groups of barriers to treatment: attitudinal barriers; discriminatory policies, practices, and procedures; and communication barriers. Appendixes include: "Bibliography," "Information Resources," "How to Refer to People with Disabilities," "Alcohol and Drug Programs and the Americans with Disabilities Act," "Resource Panel," and "Field Reviewers." (Contains approximately 150 references and 24 tables.) (JDM)

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration

Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Substance Use Disorder Treatment For People With Physical and Cognitive Disabilities

Treatment Improvement Protocol (TIP) Series

29

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The following instrument was designed by the Consensus Panel that developed this TIP. It was intended to facilitate screening clients for functional limitations that might require modifications in their treatment. The questions presented here can be administered in written form or asked as part of a verbal interview. "Yes" answers should be explored further.

Please answer the following questions keeping in mind that we are trying to get to know you better and to identify areas that may create difficulty for you in treatment if we don't know about them.

Are you currently under the care of a doctor or other medical care professional?

___ Yes ___ No

Do you take medications?

___ Yes ___ No

Do you have difficulty hearing in group settings (e.g., theaters, classrooms, family dinners)?

___ Yes ___ No

Do you frequently need people to repeat what they have said to you?

___ Yes ___ No

Have people complained that you don't hear or don't listen to them?

___ Yes ___ No

Do you wear glasses or contact lenses?

___ Yes ___ No

Do you have difficulty seeing things that are far away or very close?

___ Yes ___ No

Do you have frequent eye pain or headaches?

___ Yes ___ No

Have you ever hit your head and lost consciousness?

___ Yes ___ No

Have you ever received health or disability benefits?

___ Yes ___ No

Have you ever been unemployed for a long period of time?

___ Yes ___ No

Have you ever been fired from a job, asked to leave a job, or passed over for a promotion?

___ Yes ___ No

Did you ever have special classes or tutoring in school?

___ Yes ___ No

In a school or work setting, do you like to learn or learn best by:

- ___ Listening to someone talk
- ___ Watching someone perform a task
- ___ Reading on your own
- ___ Performing tasks yourself
- ___ Discussing things with another person
- ___ Discussing things with a group of people

Have you had problems or difficulty with any of the following?

- ___ Getting your point across to others
- ___ Sitting still
- ___ Focusing on the task at hand for more than several minutes at a time
- ___ Understanding the point that others are making to you or what others are saying to you
- ___ Communicating your feelings or thoughts to others

Have you ever had problems with or been bothered by any of the following?

- ___ Controlling anger
- ___ Remembering things
- ___ Following instructions (verbal, written, or demonstrated)
- ___ Concentrating
- ___ Becoming tired easily
- ___ Getting along with others

Have you ever had problems or been bothered by any of the following?

- ___ Depression
- ___ Anxiety
- ___ Forgetfulness
- ___ Sleep problems
- ___ Nervousness
- ___ Muscle tension or soreness
- ___ Uncontrolled worry
- ___ Excessive worry
- ___ Irritability
- ___ Restlessness (feeling on edge)
- ___ Mind "going blank"
- ___ Rapid heart rate
- ___ Pounding in chest
- ___ Heart burn or stomach pain
- ___ Uncontrolled feelings of happiness or euphoria

More information on how to follow-up on positive responses can be found on pages 20–32 of this TIP.

Substance Use Disorder Treatment For People With Physical and Cognitive Disabilities

Treatment Improvement Protocol (TIP) Series

29

Dennis Moore, Ed.D.

Consensus Panel Chair

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What Is a TIP?

CSAT Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance use disorders. CSAT's Office of Evaluation, Scientific Analysis and Synthesis draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private treatment facilities for substance use disorders as these disorders are increasingly recognized as a major problem.

The TIPs Editorial Advisory Board, a distinguished group of substance use disorder experts and professionals in such related fields as primary care, mental health, and social services, works with the State Alcohol and Drug Abuse Directors to generate topics for the TIPs. Topics are based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content for the TIP. Then recommendations are communicated to a Consensus Panel composed of non-Federal experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP. The members of each Consensus Panel represent substance use disorder treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Panel Chair (or Co-Chairs) ensures that the guidelines mirror the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the TIP is prepared for publication, in print and online. The TIPs can be accessed via the Internet on the National Library of Medicine's home page at the URL: http://isis.nlm.nih.gov. The move to electronic media also means that the TIPs can be updated more easily so they continue to provide the field with state-of-the-art information.

While each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance use disorder treatment is evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either Panelists' clinical experience or the literature. If there is research to support a particular approach, citations are provided.

This TIP, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities*, is intended to enhance treatment providers' knowledge concerning people who have a

physical or cognitive disability in addition to their substance use disorder. Treatment programs for substance use disorders already see many individuals with coexisting disabilities, but many providers fail to accommodate these individuals either because they are unaware of the disability or how accommodations can improve treatment outcomes (even though such accommodations are legally mandated). The first chapter defines and explains the issues involved in treating people with coexisting disabilities. Chapter 2 discusses how to screen for coexisting disabilities and how to adapt substance use disorder screenings for clients who have a disability. Chapter 3 discusses treatment planning and counseling; it also describes how treatment can be modified to meet the particular needs of people with coexisting disabilities. Forming linkages with other service providers is the topic of Chapter 4, and Chapter 5 presents material for program administrators. In Appendix B, there is a comprehensive list of resources. Appendix C discusses the proper language to use when referring to people with disabilities. *Alcohol and Drug Programs and the Americans With Disabilities Act*, a pamphlet from the Pacific Research and Training Alliance, is reproduced in Appendix D.

Other TIPs may be ordered by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA/CSAT's mission to improve treatment of substance use disorders by providing best practices guidance to clinicians, program administrators, and payors. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses its particular areas of expertise until it reaches a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to advances in the substance use disorder treatment field.

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Executive Summary and Recommendations

Nearly one-sixth of all Americans have a disability that limits their activity; countless others have disabilities (mostly cognitive in nature) that go unrecognized and undiagnosed. The Americans With Disabilities Act (ADA) was signed into law in 1990 to ensure equal access to all community services and facilities, including substance use disorder treatment facilities both public and private, for all people regardless of any disability they might have. People who are blind, deaf, paraplegic, and who have arthritis, heart disease, human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), mental illness, and substance use disorders are among those covered under this legislation.

People with physical and cognitive disabilities are more likely to have a substance use disorder and less likely to get effective treatment for it than those without such a coexisting disability. There are already many people in treatment who have a coexisting cognitive or physical disability. But, as many still go untreated, the number of people with coexisting disabilities entering treatment can only be expected to rise. Treatment programs have a legal and ethical responsibility to make treatment for these clients as effective as possible.

The ADA states that both public and private facilities be equally accessible for all. The law requires the installation of ramps, elevators, proper lighting, and usable doorknobs, and the removal of other physical obstacles, but accessibility means more. Barriers to communications must be removed; discriminatory policies, practices, and procedures eliminated; and attitudes changed in order to not hold a person's disability against him. Accommodating people with coexisting disabilities in treatment for substance use disorders entails such things as adjusting counseling schedules, providing sign language interpreters, suspending "no-medication" rules, and often, overcoming people's fears and ignorance. This TIP presents simple and straightforward guidelines on how to overcome barriers and provide effective treatment to people with coexisting disabilities.

The topic of substance use disorder treatment for people with coexisting disabilities is a broad one. In creating this Treatment Improvement Protocol (TIP), the Consensus Panel focused its attention on the needs of adults in treatment who had a coexisting physical or cognitive disability (including those disabilities also classified as "sensory" in nature). While people who have an affective disability (i.e., mental illness) are mentioned in the TIP, the reader is referred to TIP 9; *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (CSAT, 1994), for more

detailed information concerning the assessment and treatment of these clients.

In order to avoid awkward construction and sexism, this TIP alternates between "he" and "she" for generic examples. Since substance use disorders are considered a disability under the ADA, when people in substance use disorder treatment are referred to in the TIP as having disabilities it is understood that they have "coexisting" disabilities.

The Consensus Panel for this TIP drew upon its considerable experience in both the disability services and substance use disorder treatment fields. Panel members included providers as well as consumers of these services. Because of a lack of substantial research on the particular needs of people with coexisting disabilities in treatment for substance use disorders, the Panel often relied on clinical experience to develop the recommendations provided here. In the summary of recommendations listed below, recommendations that are supported by research literature or legislation (i.e., the ADA) are followed by a (1); clinically based recommendations are marked (2). Citations supporting the former are given in Chapters 1 through 5.

Summary of Recommendations

This TIP is organized into five chapters, the first of which presents an overview of the issues involved in providing substance use disorder treatment for people with coexisting disabilities. It provides important definitions, relevant research findings, and a discussion of barriers to treatment for people with coexisting disabilities. The second chapter presents methods of screening for disabilities and ways in which substance use disorder treatment may need to be modified for people with coexisting disabilities. Chapter 3 discusses treatment planning and counseling, and gives specific recommendations concerning how treatment can be modified to be most effective for people with specific disabilities. Information on forming and maintaining linkages with other service providers is provided in Chapter 4. The final chapter is aimed at program administrators and discusses issues such as staff training, funding mechanisms, marketing, and demonstrating an organizational commitment to working with people who have coexisting disabilities. The recommendations that follow are, however, grouped thematically and not according to the chapters in which they are found.

Making Accommodations To a Program

- Providers should examine their programs and modify them to eliminate four fundamental groups of barriers to treatment for persons with disabilities: attitudinal barriers; discriminatory policies, practices, and procedures; communications barriers; and architectural barriers. (1)
- *Accommodation* does not mean giving special preferences—it does mean reducing barriers to equal participation in the program. (1)
- When barriers cannot readily be removed, a program must find alternative methods to make its services available. (1)
- Staff training is key to overcoming most barriers to treatment, especially attitudinal barriers. Such training should be ongoing and comprehensive. All program staff should be trained in understanding functional limitations, the wide variety of conditions that lead to them, and the barriers that treatment-as-usual may present for persons with specific disabilities. Training should strongly encourage and reward staff members who find creative ways to adapt treatment procedures for people with coexisting disabilities. Because they are the initial points of contact, receptionists and

other support staff should receive special training to prepare them to respond knowledgeably and sensitively to people with coexisting disabilities. (2)

- If there is any doubt on the part of the provider regarding the legitimacy of a person's request for accommodation, a disability expert should be consulted to evaluate the request. (2)
- In general, it is beneficial and feasible to integrate people with coexisting disabilities into already existing community-based services used by nondisabled individuals recovering from substance use disorders. However, there are a number of exceptions to this rule. In instances where a legitimate, documented reason exists, specialized services may be necessary. (2)
- For clients who are blind or visually impaired, keep pathways clear and raise low-hanging signs or lights. Use large letter signs and add Braille labels to all signs and elevator buttons. Make oral announcements; do not rely on a bulletin board. (2)
- People who are blind or visually impaired will require assistance to orient themselves to a new environment. The treatment provider should give clients who are blind a complete orientation to the facility the first time they visit; the client can be guided by holding her arm just above the elbow and walking with her through the rooms, explaining where the doors, furniture, and other features are. (2)

Screening for Disabilities

- Because many disabilities are not obvious, it is important to screen for them in every person, not just those with obvious functional limitations. Ask all clients entering treatment whether they require any accommodations in order to participate. (2)
- It is the level of abilities and of the functioning of the individual—not the simple determination of whether an impairment exists—that must be assessed if screening is to lead to an effective treatment plan. In situations where a diagnosis of disability is needed (e.g., to qualify for special services) treatment providers should refer the client to a disabilities services professional. (2)
- Although it is a good idea to get background information from as many sources as possible, interview the person alone, if possible. Having others present often distorts the quality of the interview. (2)
- Intake interviews should begin with an open and friendly question, not one that is focused on the person's disability. (2)
- An intake interview should address the eye condition and blindness adjustment skills of people who are blind or visually impaired. The counselor should ascertain the pathology of the loss of vision (if it was congenital, adventitious, or traumatic), and precisely how much vision remains. (2)
- If there are forms to be completed as part of intake processing, people who are blind must have the option to complete them in the medium of their choice (Braille, large print, audiocassette, or sighted assistance). Individuals who are both deaf and blind will need a tactile interpreter to translate for them during the admissions process and afterward. (2)
- Due to the wide range of reading abilities among people who are deaf, paper and pencil should never be utilized to gather detailed assessment information. Written English forms and questionnaires should be interpreted into sign language for these clients. (2)
- When screening people with cognitive disabilities, be as specific as possible—rather than asking if they "use alcohol," ask if they like to drink beer, wine, wine coolers, etc. It may help to use props such as different glass or bottle sizes rather than asking how many ounces were consumed. (2)

Treatment Planning

- For treatment to succeed, all clients must understand the particular strengths that they can bring to the recovery process. A strengths-based approach to treatment is especially important for people with disabilities, who, because they have so frequently been viewed in terms of what they cannot or should not attempt, may have learned to define themselves in terms of their limitations and inabilities. (2)
- It is key to the treatment planning process for the treatment provider to learn where a person with a disability is on the spectrum of understanding and accepting his disability. (2)
- No treatment plan should be static, and treatment providers must continually evaluate and revise the treatment plan with assistance from clients with disabilities. Treatment plans should be flexible enough to take into account changes in a person's condition or new knowledge gained during treatment. Clients with traumatic brain injury, for example, often show a dramatic recovery curve over the year to two years following their accidents. (2)
- An individual with a disability may also need to explore several methods for learning something or fulfilling a goal before an accomplishable approach to the situation can be identified and implemented. (2)
- The treatment plan should document all alterations to the usual treatment procedures that are being made. If an approach does not work, the outcome should still be carefully documented to prevent duplication of effort by other programs in the future. Similarly, details of what is successful for a person should be documented, particularly for persons with cognitive disabilities who may not be able to tell future caregivers which treatments have been effective and why. (2) Documentation of all efforts at accommodation is needed to verify ADA compliance. (1)
- It is helpful to identify early on any needed exceptions to the routines of the treatment program for a person with a disability and to explain to other clients that the accommodations for a person with a disability simply give her the help she needs to meet shared goals. If the client does not object, the exceptions and the rationale for these exceptions should be discussed openly in group meetings. (2)
- Behavioral contracts with people with coexisting disabilities may need to be more explicit than those with other people, and the consequences for relapses in particular may need to be specifically tailored to what the individual is realistically capable of achieving. (2)
- People who are deaf or hard of hearing (and probably those with other disabilities as well) generally know less about addiction and recovery when they enter treatment than nondeaf (or nondisabled) people, and therefore they will often require lengthier treatment. Treatment providers should be prepared to allow for longer treatment times for clients with disabilities. (1)
- It is essential that all clients participate in planning leisure activities, and programs with rigid approaches that exclude clients from such participation should consider changing their policies. (2)
- If a person with a disability has limited transportation options, conduct individual counseling by telephone, go to the person's house, or meet at a rehabilitation center or other alternative site. The Consensus Panel recommends that providers make home visits if necessary, which may be reimbursable under case management services. (2)
- For people with coexisting disabilities, failure to achieve treatment goals may indicate that

the treatment plan lacks the discrete steps necessary to meet those goals. In setting a goal, the client and the counselor must work closely to understand all the physical and cognitive requirements of meeting a goal. (2)

- Early in treatment, a medical professional should conduct an assessment of all the client's medications—both prescribed and over-the-counter, including herbs and vitamins. In addition, the Panel recommends that a single medical professional try to monitor the client's medication regimen. Under no circumstances, however, should other treatment staff advise clients to take or not to take particular medications, vitamins, or herbs. (2)
- Lack of employment may be a factor in substance abuse; conversely, addressing and overcoming barriers to employment, with the aid of collaborative partners, may greatly enhance the prospect for recovery and should be addressed as a component of treatment planning. (2)

Counseling

- Counseling session times should be flexible, so that sessions can be shortened, lengthened, or more frequent, depending upon the individual treatment plan. (2)
- For people with cognitive impairments, it is important to remember to ask simple questions; to repeat questions; and to ask the client to repeat, in her own words, what has been said. Discussions should be kept concrete. People with mental retardation or traumatic brain injury may not understand abstract concepts; they should be asked to provide specific examples of a general principle. (2)
- The use of verbal and nonverbal cues will help increase participation and learning for people with cognitive disabilities and make the group sessions run more smoothly for all. The counselor and the person with a disability together can design the cues but should keep them simple, such as touching the person's leg and saying a code word (e.g., "interrupting"). (2)
- Clients with cognitive disabilities will often benefit from techniques such as expressive therapy or role-playing. (2)
- Assignments that require the use of alternative media in place of writing may work best with clients who have cognitive disabilities as well as those who are deaf. (2) Clients who are blind will need assignments translated into their preferred method of communication (e.g., Braille, audiotape), but no matter what method is used they will require more time to complete reading assignments. (1)
- Regardless of the model of communication used by the person who is deaf or hard of hearing, the visual aspect of communication will be important. Therefore, it is important to look directly at the person when communicating. This will allow him to try to read the lips of the counselor and to see her facial expression. (2)
- Interpreters should usually be provided for people who are deaf or hard of hearing. (1) The interpreter should be a neutral third party hired specifically to interpret for the counselor and the person who is deaf; a family member or friend of the client should not be used as an interpreter. Use only qualified interpreters as determined by either a chapter of the Registry of Interpreters for the Deaf or a State interpreter screening organization. (2)
- If a person who is deaf is using an interpreter, group members will need to take turns during discussions. When addressing a person who is deaf the counselor or group members should speak directly to the person as if the interpreter is not present. (2)
- When working with an individual with a physical disability, make certain that table

surfaces are the correct height, and in particular that wheelchairs can fit beneath them. Counselors should try to place themselves so that they are no higher than the client. They should be aware of the pace of the interview, and attempt to gauge when clients are becoming fatigued. Counselors should periodically inquire how the client is doing and offer frequent breaks. (2)

- People who use wheelchairs often come to regard the chair as an extension of themselves, and touching the chair may be offensive to them. Never take control of the wheelchair and push the person without permission. (2)
- For individuals with cognitive disabilities, providers must systematically address what has been learned in the program and how it will be applicable in the next stage of treatment or aftercare. Some people are very context-bound in their learning, and providers cannot assume that the lessons learned in treatment will be applied in aftercare. (2)
- In planning and providing treatment to people with disabilities, the importance of asking questions cannot be overemphasized. Asking before rendering any service is a basic principle. (2)

Linkages

- Coordination with an agency providing case management services for people with disabilities should be a priority if those services are not already being provided by the substance use disorder treatment program. Treatment plans for people with coexisting disabilities should address problems such as unemployment, a lack of recreational options, social isolation, and physical abuse because they are more likely than the general population to experience these situations. (2)
- Service linkages are essential to provide effective substance use disorder treatment for people with coexisting disabilities. (2)
- Treatment providers need to be able to identify what ancillary services are available for their clients, and be able to access those services and funding sources. (2)
- Since a client having a substance use disorder and a disability may also be in a physical rehabilitation or other disability program, treatment professionals should be aware of the various approaches used by these other programs, and know how to collaborate with them. The Panel recommends cross-training between vocational rehabilitation or other disability service providers and substance use disorder treatment providers to help treatment professionals understand the impacts of both disability and substance use disorders. (2)
- In developing partnerships with referring agencies, the treatment program should ensure, through interagency agreements, that mechanisms are in place for exchanging client information. (2)
- It is not unusual for services to be duplicated or ineffective when a case manager is not utilized, and so a substance use disorder treatment provider may need to either case manage these services or find another organization or person to do so. A case manager can be a strong advocate for a person with a disability and help her locate appropriate and accessible services. (2)
- A substance abuse counselor may not have the time or the expertise to work on all the issues that arise because of a client's disability. If that is the case, a referral to a peer counselor at a Center for Independent Living, whose job it is to help disabled individuals come to terms with the limits of their disabilities, may be in order. The two counselors can work together as a team. (2)

- The treatment provider should investigate whether accommodations will be made for a client with a coexisting disability before sending him to an aftercare facility. (2)

Organizational Commitment

- Providers must be prepared to act as advocates for their clients when services and supports that are normally readily available and effective prove inaccessible for the client. (2)
- When treatment teams make the effort to accommodate individuals with coexisting disabilities, the quality of care improves for all clients. All clients can get more out of treatment that is individualized and that takes their specific functional capacities and limitations into account. (2)
- To ensure full organizational support for treating people with coexisting disabilities, the Consensus Panel recommends that a treatment program develop a policy statement that articulates the program's willingness to accommodate any individual with a disability who chooses to attend the program. (2)
- When a program makes a commitment to serving people with coexisting disabilities, board membership of people with disabilities may be implemented immediately or considered as a goal to be reached as the program begins to serve a greater number of people from these groups. A program should try to obtain regular input from the community it seeks to serve; creating a permanent task force or an advisory committee is an ideal way to address this need. (2)
- The organization must make a commitment to continually reexamine the program's effectiveness for people with coexisting disabilities. Such inquiry can take place both formally, using quality assurance methods and consumer satisfaction surveys, and informally, through opportunities for individual and group feedback with program staff. (2)
- It is not enough for a program simply to be ready to serve people with coexisting disabilities. Rather, the program should be proactive in making the disability community aware of its services to ensure that disability organizations will support referrals to the program. (2)
- Another sign of organizational commitment is to hire people with disabilities to work in the treatment program. Hiring people with disabilities also benefits other staff members, who can learn from these coworkers. (2)
- The Consensus Panel recommends an "open door" policy that states that all clients are entitled to an assessment if they are presenting with a chemical dependency problem, regardless of whatever other problems they may appear to have. If the proper course of treatment is not available at the facility, it is still possible to perform a substance use disorder assessment and refer the client for treatment elsewhere. (2)

Improving Treatment for All Clients

Treatment that is planned and provided on a case-by-case basis will benefit everyone, not just those clients with coexisting disabilities. All people have different functional capacities and limitations, and an evaluation of these, as described and encouraged in this TIP, will help providers focus on individual needs. This TIP explores the treatment needs of people with particular types of disabilities, but the processes of assessment and evaluation it suggests can help all clients gain greater benefit from treatment.

There is a growing belief in the substance use disorder treatment field that treatment is more successful if it can respond to all the needs of an

individual, not just the need to stay away from alcohol and drugs. If treatment is to succeed for a client with a coexisting disability, a wide range of services may be required. For this reason, this TIP strongly encourages the use of case management services and service linkages. The TIP also aims to educate people in both the disability services and substance use disorder treatment fields concerning the problems faced by people who have both a substance use disorder and a coexisting disability. A better understanding of the needs of these clients and the services available to them can be gained through reading this TIP.

1 Overview of Treatment Issues

In 1990, it was estimated that 36.1 million people in America (14.5 percent of the population) had a disability that limited their functioning in some manner (LaPlante, 1992). A great number of people with disabilities have struggled for years with barriers to employment, inaccurate and hurtful stereotypes, and inaccessible community services. In order to redress these barriers that affect millions of Americans, President Bush in 1990 signed into law the Americans With Disabilities Act (ADA), the most significant civil rights legislation in two decades. The legislation prohibits discrimination on the basis of disability, including substance use disorders (See Figure 1-1), and guarantees full participation in American society, including access to community services and facilities, for all people with disabilities. It makes provision for many accommodations that may be necessary in substance use disorder treatment, such as the use of large print materials, reading services, attended care, adaptive equipment such as listening devices, and flexible schedules to accommodate different physical needs. Because of this legislation, many people today are more aware of the problems faced by people with physical and cognitive disabilities.

Though the ADA is correcting the situation, many people with disabilities remain stigmatized and shut out. They are also at much higher risk than the rest of the population for substance abuse or dependence. A study of adult males receiving treatment for alcoholism, for instance, revealed that 40 percent had a history indicative of learning disabilities (Rhodes and Jasinski, 1990). Another study indicated that at least one half of persons with a substance use disorder and a coexisting disability are not being identified as such by the systems providing them services (Rehabilitation Research and Training Center on Drugs and Disability [RRTC], 1996).

New York State maintains within their Office of Alcoholism and Substance Abuse Services (OASAS) some of the most comprehensive records in the country on substance use disorder services for persons with disabilities. The OASAS client services statistics for 1997 showed that of 248,679 clients served by licensed facilities in New York, a total of 55,719 (or 22.4 percent of the total clientele) were recorded as having a coexisting physical or mental disability. Of these clients, 58.9 percent had a disability not related to mental illness (e.g., mobility impaired, visually impaired, deaf) (OASAS, 1998). These records were generated by treatment staff personnel who were not necessarily trained in disability assessment or by client self-reports, which suggests that some disabilities (e.g., traumatic brain injury [TBI], learning disability, attention deficit/hyperactivity disorder [AD/HD]) may be greatly under-reported. Given that these "hidden" conditions affect more than half of all special education students, coexisting disabilities may actually affect up to 40 percent

Figure 1-1
Substance Use Disorders as a Coexisting Disability

Chemical dependency is called a disability and covered as such under the provisions of the Americans With Disabilities Act (ADA). Substance abuse is an illness that frequently results in serious functional limitations or death when not properly treated. If an individual has both a substance use disorder and a physical or cognitive disability, then he is really coping with coexisting disabilities. However, for the purposes of this Treatment Improvement Protocol (TIP), the term "disabilities" will refer to physical and cognitive disabilities and *not* substance use disorders. When the TIP refers to a person with a "disability," therefore, it should be understood that it is a coexisting disability.

of all clients served by substance use disorder treatment programs.

Yet despite the prevalence of substance use disorders among people with disabilities, these individuals are less likely to enter or complete treatment (de Miranda and Cherry, 1989; Kirubakaran et al., 1986; Helwig and Holicky, 1994; Schaschl and Straw, 1989). This is because physical, attitudinal, or communication barriers often limit their treatment options or else render their treatment experiences unsatisfactory.

Fortunately today, substance use disorder treatment providers are better able to face the challenges of accommodating people with coexisting disabilities because they have already had the experience of making treatment modifications for other constituencies. Over the past decades, the substance use disorder treatment field has matured through the challenges of treating populations with specific needs, such as women, adolescents, people from various racial and ethnic minority groups, and gay men and lesbians. The effectiveness of treatment has improved as a result—it has become more developmentally and culturally specific, flexible, and holistic. Rather than placing a person in an established treatment "slot," treatment providers are learning the importance of modifying and adapting services to meet an individual client's needs. Thus, the knowledge and skills necessary to adapt a treatment program to meet the needs of people with coexisting disabilities are a logical extension of existing principles.

Disabilities can be classified as physical, sensory, cognitive, or affective (see Definitions section below). This TIP addresses the problems that may arise when treating people with the first three types; providers treating people with affective impairments (often called dually diagnosed persons) are referred to TIP 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*. This TIP targets substance use disorder treatment providers with little or no experience treating people with physical, cognitive, or sensory disabilities. These providers may be prompted to address disability issues because of the ADA, or perhaps they are treating their first-ever client with deafness, TBI, spinal cord injury, or another disability. This TIP will help them screen, assess, refer, and treat this large and underserved population.

Definitions and Terminology

Physical and cognitive disabilities are very sensitive topics for discussion and providers need to pay attention to the language they use to discuss this issue. Appendix C presents specific guidelines on how to refer to persons with disabilities in a respectful, sensitive manner. As

a general rule, one should always put people first, before their disabilities, referring to "persons with disabilities" rather than "disabled people." One should never refer to the disability in place of the person (not "the retarded" but rather "people who are retarded"). Nor should one call a person with a disability a "patient" or "case," unless it is to refer to his relationship with his doctor.

Disabilities

Diseases, disorders, and injuries, whether congenital or acquired, can have various effects on organs and body systems. Conditions (and *diseases*) such as multiple sclerosis, TBI, spinal cord injury, diabetes, and cerebral palsy can lead to *impairments*, such as impaired cognitive ability, paralysis, blindness, or muscular dysfunction. These impairments in turn cause *disabilities*, which limit an individual's ability to function in various areas of life, such as learning, reading, and mobility. While diseases, impairments, and disabilities are distinct categories, they are often used interchangeably; to ensure clarity, they are defined in Figure 1-2.

The field of disability services has developed its own terminology to discuss physical and cognitive disabilities, and many substance use disorder treatment providers will not be familiar with these terms. The terms used throughout the TIP (and in the field of disability services) are defined below.

The World Health Organization (WHO) has devised a method for the classification of impairments and disabilities (World Health Organization, 1980). This complex system has been simplified here into four main categories:

1. *Physical* impairments are caused by congenital or acquired diseases and

Figure 1-2
Some Definitions

The definitions that follow explain the terms used in this TIP:

Disease: An interruption, cessation, or disorder of body functions, systems, or organs.*

Impairment: Any loss or abnormality of psychological, physiological, or anatomical structure or functions.**

Disability: Any restriction or lack (resulting from an impairment) of the ability to perform an activity in the manner or within the range considered normal for a human being. A disability is always perceived in the context of certain societal expectations, and it is only within that context that the disadvantages accruing from a disability (often called "handicaps") can be properly evaluated.**

Functional capacities: The ability or degree of ability possessed by the individual to meet or perform the behaviors, tasks, and roles expected in a social environment.***

Functional limitations: The inability to perform certain behaviors, fulfill certain tasks, or meet certain social roles as a consequence of a disability. Those limitations can be anatomical (e.g., amputation), physiological (e.g., diabetes), cognitive (e.g., traumatic brain injury), or affective (e.g., depression) in origin and nature. They represent substandard performance on the part of the individual in meeting life activities and reflect the interaction between the person and the environment. (A list of the seven areas of functional capacities and limitations most often assessed follows on page 5.)***

**Source:* Stedman, 1990.
***Source:* World Health Organization, 1980.
****Source:* Livneh and Male, 1993.

disorders or by injury or trauma. For example, spinal cord injury is a disorder that can cause paralysis, an impairment.

2. *Sensory* impairments include blindness and deafness, which may be caused by congenital disorders, diseases such as encephalopathy or meningitis, or trauma to the sensory organs or the brain.
3. *Cognitive* impairments are disruptions of thinking skills, such as inattention, memory problems, perceptual problems, disruptions in communication, spatial disorientation, problems with sequencing (the ability to follow a set of steps in order to accomplish a task), misperception of time, and perseveration (constant repetition of meaningless or inappropriate words or phrases).
4. *Affective* impairments are disruptions in the way emotions are processed and expressed. For the purposes of this discussion, affective impairments are considered to include problems caused by both affective and mood disorders, such as major depression and mania. These impairments include the symptoms of mental disorders, such as disorganized speech and behavior, markedly depressed mood, and *anhedonia* (joylessness).

Figure 1-3 categorizes various disabilities according to these four classifications; however, some conditions may be more difficult to categorize and some individuals may experience multiple conditions.

Figure 1-3
Disability Chart

Category	*Disability*
Physical	Spina bifida Spinal cord injury Amputation Diabetes Chronic fatigue syndrome Carpal tunnel Arthritis
Cognitive	Learning disability Traumatic brain injury Mental retardation AD/HD
Affective	Depression Bipolar disorder Schizophrenia Eating disorder Anxiety Posttraumatic stress disorder
Sensory	Blindness Deafness Visual impairment Hard of hearing

Functional Capacities and Limitations

People may have the same disability without having the same functional capacities and limitations. It is, however, their capacities and limitations that will determine what accommodations should be made to the treatment plan. Treatment providers should look at each individual when determining the level and type of service needed rather than prescribing an approach or course of treatment based on the disability diagnosis. For example, one person with TBI may require a period of specialized services because of problems with attention span, unconstructive behaviors, or medical needs. Someone else with TBI may be stable enough to be integrated with nondisabled persons with minimal accommodation.

Though this TIP addresses accommodations and adjustments by disability, functional limitations are actually what will drive program modifications. There are seven categories of functional capacity and limitation that can impinge on a person's treatment. They are listed below with some of the specific functions that fall under each category.

1. Self-care
   - Eating
   - Grooming
   - Bathing
   - Dressing
   - Bowel and bladder management
   - Medication usage
2. Mobility
   - Positioning
   - Walking, with or without assistive devices
   - Use of wheelchair or other mobility aid
   - Use of stairs
   - Ability to operate motor vehicle
   - Use of public transportation (or other access to transportation)
3. Communication
   - Reading
   - Writing
   - Speaking
   - Listening
4. Learning
   - Attention
   - Comprehension
   - Retention
   - Application
5. Problem-solving
   - Awareness and recognition of problems
   - Identification of alternatives
   - Anticipation of possible consequences of various alternatives
   - Deciding on optimal alternative
6. Social skills
   - Understanding of social mores and values
   - Impulse control
   - Intimacy
   - Conversational skills
   - Empathy
7. Executive functions
   - Planning and organization
   - Motivation and initiation
   - Monitoring and reviewing
   - Decisionmaking

Disabilities and Chemical Dependency

Data from the Robert Wood Johnson Foundation indicate that about 10 percent of the population have a substance use disorder (Robert Wood Johnson Foundation, 1994). Yet studies have consistently found that 20 percent or more of all persons qualifying for State vocational rehabilitation services exhibit symptoms qualifying them for a diagnosis of substance abuse or substance dependence (Moore and Li, 1994; Schwab and DiNitto, 1993; RRTC, 1996). In the 1996 RRTC study, the disabilities

represented included those most prevalent within State vocational rehabilitation (VR) systems: mental illness, various orthopedic impairments, deafness/hearing impairments, blindness/visual impairments, learning disability, mental retardation, TBI, and chemical dependency. In a subsequent analysis, persons with the primary disability of chemical dependency were omitted from the sample. Yet the remaining VR consumers with other disabilities reported patterns of illicit drug use that were more frequent and heavier for every drug compared with a general population sample matched for age and geographic distribution (RRTC, 1996).

In 1988, the Wisconsin Department of Health and Social Services conducted a statewide study of alcohol use by people with disabilities (Buss and Cramer, 1989). It asked 3,216 consumers of VR or independent living services (people who had disabilities such as orthopedic impairments [including spinal cord injury and amputation], vision impairments, loss of hearing, arthritis, cerebral palsy, polio, brain trauma, heart disease, and multiple sclerosis) to report their use of alcohol. Alcohol use patterns were based on typologies established by Cahalan (Cahalan et al., 1969). The study found that respondents with a disability were more likely to be "heavy" or "moderate" drinkers (35 percent and 25 percent, respectively) than the general population. While heavy or moderate drinkers are not considered dependent, this heavy alcohol use puts them at higher risk for injury and other health consequences, as well as future risk of dependence. The results of this study suggest that people with disabilities may use alcohol at least as much if not more than the general population.

Not all people with disabilities are equally likely to have substance use disorders. Certain types of disabilities seem to have more impact than others on substance use behavior. For instance, research suggests that the rate of substance abuse among people with mental illness may be twice as high as that of the general population, and over 50 percent of young people with mental illness report some kind of substance use (Kelley and Benshoff, 1997; Kessler and Klein, 1995; Regier et al., 1990; Brown et al., 1989). Substance use is often the major contributing factor to both spinal cord and traumatic brain injuries, and people living with the aftereffects of such trauma often continue to have substance use disorders (Heinemann et al., 1988; Sparadeo and Gill, 1989; Corrigan et al., 1995).

Both disability and chemical dependency service providers report increases in substance use disorders among people with disabilities. For example, State directors of alcohol and drug departments and directors of State VR agencies reported increases in coexisting disability and substance use disorders among recent referrals to their programs. Directors of both agencies predicted that these numbers would continue rising in the future (RRTC, 1996). Since many people with disabilities are not currently receiving the treatment for substance use disorders they require, the number of people with disabilities seeking treatment can only be expected to grow.

Life Problems Contribute to Substance Use Disorders

People with disabilities are more likely to use substances in part because they experience unemployment, lack of recreational options, social isolation, homelessness, and victimization or physical abuse more frequently than the general population (Susser et al., 1991; Vash, 1981; DeLoach and Greer, 1981; Marshak and Seligman, 1993). If they also have substance use disorders, such problems are further exacerbated.

Many adults with disabilities are underemployed or unemployed. Some 30 percent live below the poverty line, a rate

approximately 20 percent higher than that for people without disabilities (LaPlante et al., 1997). People with disabilities at all income levels generally spend a large proportion of their income to meet their disability-related needs. Like others who have been isolated or unemployed over a long period of time, some people with disabilities lack the social skills and familiarity with workplaces needed to succeed in a job.

For many reasons, people with disabilities may rely on a smaller social network. They may be isolated because of their families' efforts to protect them, the physical difficulty of getting out to social settings, lack of opportunities to practice social skills, lack of physical stamina, trouble finding activities and negotiating transportation, poverty, and nondisabled people's discomfort with people with disabilities. An altered body image can make those with a recent disability onset (e.g., people using a wheelchair for the first time) reluctant to socialize. Additionally, physical limitations make some people fear violence or exploitation. People with disabilities are at greater risk of being victims of sexual abuse and domestic or other violence (Glover et al., 1995; Varley, 1984). They are more likely to be victimized because they are perceived as unable to protect themselves. Depression and low self-esteem associated with their disabilities can also play a role in some individuals' victimization, and in turn their substance use.

Isolation and functional limitations leave many people with disabilities with few recreational options, yet they often have much unstructured time on their hands. For example, people who are blind or have a visual impairment may face increased isolation, excess free time, and underemployment (Motet-Grigoras and Schuckit, 1989; Nelipovich and Buss, 1989). Some people may perceive bars or other places where alcohol is consumed as the only social gathering places open to them and drinking or drug use the only possible means of recreating or gaining social support (Greer, 1986).

Panel members report that employed assistants and caregivers for people with disabilities may often abuse their clients, steal from them, or otherwise exploit them. The caregiver for a substance-using client with a disability may purchase alcohol or drugs for the client or tolerate the client's self-destructive behavior.

Treatment implications

Each of these life problems increases the individual's risk of substance use disorder, makes treatment more complex, and heightens the possibility of relapse. Coordination with an agency providing case management services for people with disabilities should be a priority if those services are not provided by the substance use disorder treatment program. People with both a substance use disorder and a coexisting disability may need assistance and individualized accommodations to

- Escape from abusive situations
- Learn to protect themselves from victimization
- Find volunteer work or other means of gaining a sense of productivity in lieu of paid employment (although paid employment would always be preferred)
- Develop prevocational skills such as basic grooming, dressing appropriately, using public transportation, and cooking
- Learn social skills that may be missing because of both substance use disorders and disability-related problems
- Learn to engage in healthy recreation
- Become educated about their legal rights to accessible environments and services as well as employment
- Obtain financial benefits to which they are entitled
- Build new peer networks

Programs face procedural and other obstacles when they attempt to rectify such problems. For example, clients may be declared ineligible for some VR programs until they have remained sober for 6 months or more (even though such a requirement is counter-productive and can act to maintain a vicious cycle between a lack of vocational skills and substance use disorders). Some VR counselors resist working with people with substance use disorders, believing them too "difficult" and destined to fail. Furthermore, by the time a person with a disability attempts to access treatment, the level of her substance use disorder may be rather severe because of societal enabling, systems that do not identify early substance use and abuse, and the tendency among human service agencies to focus on disability rather than chemical dependency issues.

Obvious Versus Hidden Disabilities

Identifying hidden disabilities is the key to successful substance use disorder treatment. A patient who repeatedly fails at treatment may not understand what he is told, or may not be able to read or remember materials. Many people who have disabilities (e.g., people with multiple sclerosis, seizure disorders, cardiac problems) look healthy much of the time, but these conditions often cause significant fatigue or limitations on walking, driving, or other physical activities. Treatment staff members may not accept or believe a client has a disability based on what they see, regardless of what the client says. In some cases, people may have had a lifelong investment in hiding their cognitive disabilities and will not volunteer or admit to their conditions.

Disabilities can also be hidden from clients themselves. A substance use disorder treatment program may be where a person first discovers she has diabetes, a learning disability, or a hearing loss. Even if a client knows he has a disability, he may not be aware of accommodations that could help him function better.

Whether they recognize it or not, treatment providers are already delivering services to a variety of people with disabilities. Some of these may be the same people who drop out of treatment, who do not seem to make progress, or who seem unmotivated. Such clients can be particularly frustrating for treatment providers; however, if functional limitations are recognized and treatment is modified accordingly, the program is likely to see better results.

The counselor must be especially sensitive when working with people who are not aware of or wish others to remain unaware of their disability. Chapter 2 elaborates some of the ways in which treatment staff can screen for cognitive disabilities that may not be readily apparent.

Hidden cognitive disabilities

Physical and sensory disabilities are generally more apparent than cognitive disabilities. Several studies have indicated that many people requiring chemical dependency treatment have cognitive, personality, or other conditions that affect their ability to learn or benefit from treatment (Corrigan, 1995; Brown et al., 1989; Rourke and Loberg, 1996). Provider experience bears out the fact that a number of persons present to the treatment setting with undiagnosed or misdiagnosed cognitive impairments. Treatment providers should look out for these potential hidden disabilities, because they may not have been documented by previous health care professionals, may not be fully appreciated by the client, or may have been misinterpreted in the past as "poor motivation" on the part of the client.

The majority of individuals with mental retardation is in the mild to borderline range (IQ up to 83) and can function well in many treatment situations with minimal adaptations.

However, people with mental retardation and other cognitive disabilities may have very good social and communication skills and yet still have serious problems with memory, decisionmaking, planning, or learning comprehension. Some highly functioning individuals go to great lengths to keep their disabilities a secret, even presenting with noncompliant or negative behavior to deflect attention from their areas of functional limitation.

Hidden physical disabilities

One cannot ascertain the nature of someone's limitations based on obvious physical impairments. A person who speaks slowly due to cerebral palsy may be able to read and process information quite well. On the other hand, someone who uses a wheelchair may in fact face a more serious impairment in an unrelated learning disability that dramatically limits his ability to read. Some persons with physical disabilities may have had to deal with so many disappointments that they have seriously lowered their own expectations of what they can do; in these situations, these individuals' physical disabilities may be less of an impediment to recovery than their lowered expectations.

Recognizing Barriers to Treatment

In spite of two recent Federal laws (the 1992 Amendments to the Rehabilitation Act of 1973 and the Americans With Disabilities Act of 1990), substance use disorder treatment programs continue to provide inadequate services for people with disabilities. Although this difficulty is most visible in inpatient or residential programs, statewide legal proceedings on behalf of people with disabilities have been initiated regarding access to outpatient settings as well. According to the ADA, programs must remove or compensate for physical or architectural barriers to existing facilities when accommodation is readily achievable, meaning "easily accomplishable and able to be carried out without much difficulty or expense" (P.L. 101-336 §301). Providers should examine their programs and modify them to eliminate four fundamental groups of barriers to treatment for people with disabilities: (1) attitudinal barriers; (2) discriminatory policies, practices, and procedures; (3) communications barriers; and (4) architectural barriers. (For a more detailed explanation of what accommodations must be made, and answers to other, more specific, questions concerning ADA compliance and the best ways to overcome these barriers, see Appendix D).

Attitudinal Barriers

Attitudes about "disability" influence the ways nondisabled people react to people with disabilities, which can affect the latter's treatment outcomes. The stereotypes and expectations of others also influence the ways people think about their own disabilities.

Perceptions, stereotypes, or beliefs held by providers can hinder their ability to treat a person with a disability. Following are some examples of commonly held beliefs that can pose barriers to treatment:

- People with disabilities do not abuse substances.
- People with disabilities should receive exactly the same treatment protocol as everyone else, so that they aren't singled out as different. Being mainstreamed into society means that you should do exactly the same things as everyone else.
- A person is noncompliant when her disability prevents her from responding to treatment.
- A person with a disability will make other clients uncomfortable.
- People with disabilities will sue the program regardless of the services offered.

- Serving people with disabilities requires going to extremes.
- Every person with a disability requires hospitalization rather than a residential or outpatient program.
- People with cognitive disabilities are not capable of learning how to stay sober.
- People with disabilities make too many demands and use their disability as an excuse for not fully participating in treatment.
- People with disabilities deserve pity, so they should be allowed more latitude to indulge in substance use.

Staff members who hold such beliefs about people with disabilities may screen out those who would be well served by their programs or deny a client an appropriate accommodation for her disability. On the other hand, these staff members may unwittingly enable clients to use their disabilities to avoid treatment. (For examples of inappropriate responses, see Figure 3-1 on Denial, Enabling, and Accommodation.)

Staff training is key to overcoming attitudinal barriers. For more information on staff training, see Chapter 5 for the discussion of Provider Knowledge of People with Disabilities. To learn the appropriate terms to use in referring to people with disabilities see Appendix C: How to Refer to People With Disabilities.

Discriminatory Policies, Practices, and Procedures

Programs can inadvertently discriminate when their policies, practices, or procedures present barriers to the treatment of people with coexisting disabilities. For example, a program may establish a discriminatory policy such as the following:

- We do not serve clients who are taking medication (even if the medication is for a medical condition, such as epilepsy). (Such discrimination is also often seen against clients in opioid maintenance therapy or those who require psychoactive medications for a psychiatric condition.)
- People who miss appointments must pay fines (even though disability-related problems may make it impossible for a person to make a scheduled appointment)
- Fire and safety regulations require that all clients be able to walk out of the building independently (which precludes the participation of a person who uses a wheelchair).
- All clients must participate in house chores such as washing dishes and mowing the lawn (which precludes the participation of people with particular physical disabilities).
- Every person must read two chapters of a book per day (even if some people do not have the necessary reading skills).

Examples of discriminatory practices include the following:

- A client is excluded from the residential setting because he needs assistance in transferring from the wheelchair to the bed (even though this task is readily learned by program staff and is required only twice per day for 2 minutes at a time).
- A client is discharged from outpatient treatment for missing three sessions, when the client was actually delayed by waiting for a "handicapped-accessible" bus that does not run on a set schedule.

The ADA sets forth many requirements to protect people with disabilities from administrative barriers. Programs should periodically review their existing policies, practices, and procedures and adopt new ones as needed in order to avoid discrimination. Rules and treatment plans can be specifically tailored to meet the needs of each person, and consequently the specific treatment requirements will vary for some people. An individualized treatment approach permits

more latitude in assigning different types of chores or homework to individuals and in using different techniques or learning modalities (e.g., allowing a client who has great difficulty speaking in a group setting to turn in an oral report on audiocassette). Also, when all clients receive individualized treatment there will be less friction when one client is permitted to do an assignment differently.

Barriers to Communication

These barriers exist when a program's communications with people with coexisting disabilities are less accessible than its communications with others. To eliminate communications barriers, programs should have available a wide range of auxiliary aids and services.

Communications with people with physical disabilities

Persons with slow speech, significant respiratory problems, or other limitations in expression have a great deal of difficulty expressing their thoughts fully. Consequently, treatment staff has less information to guide its therapeutic actions. Ironically, this occurs most often with clients who need to be better understood by their counselors in order to progress in treatment. A counselor or clinician is confounding the potential success of treatment by not allowing clients who have delays in speech or cognition sufficient time to fully express their thoughts.

Speech impairments can result from a stroke or from a condition such as cerebral palsy. Auxiliary aids for individuals with speech impairments include telecommunication devices for the deaf (TDDs), computer terminals, speech synthesizers, and communication boards.

Communications with people with sensory disabilities

A person who is deaf and blind may require the use of a sign language interpreter trained in the use of tactile communication. People who are blind or visually impaired use a wide range of communication techniques, and one should not assume that all people who are blind are Braille-literate. Providers should find out from the blind person her primary communication method and provide materials in that medium. The provider should be able to supply materials in Braille, large print, and audiocassette. Local, State, or private agencies for the blind can either transcribe or help arrange transcription of printed material into these media.

Inadequate communications are the major barrier to treatment for people who are deaf and hard of hearing. Without accommodation, people who are deaf, whether they use sign language or not, will experience barriers to communication that significantly reduce their ability to benefit from a treatment program and to receive services equivalent to those hearing clients receive. Various auxiliary services and devices can help a person who is deaf communicate with program personnel.

An individual who is deaf can experience his first barrier when he calls a program to apply for admission. A treatment program should have a TDD (also referred to as a TTY), which enables people to type and send messages over the telephone network. If a treatment program has a TDD, people who are deaf can call the program directly.

Once the individual who is deaf has been admitted to the program, someone will have to translate the spoken communication that comprises most of the program. Clients who are deaf and use sign language will need sign language interpreters in order to have access to communication. Individuals whose first language is American Sign Language (ASL) know written English as a second language, and may have the same difficulties with it that other nonnative speakers have. Interpreters should be available at all times so that clients who are deaf can fully participate in the program; if there are

no staff who use sign language then one or more outside interpreters will need to be hired.

Treatment programs can contact their State commission for the deaf and hard of hearing or the agency in their State that focuses on deaf and hard of hearing service provision. Most States also have a chapter of the Registry on Interpreters for the Deaf (RID), the professional association for sign language interpreters, to help people obtain the services of a qualified interpreter. As a general rule, an interpreter who is certified by the RID is considered qualified. However, in some States there is a screening system to determine if interpreters who have not yet received certification from the RID are able to provide quality interpreting services. In these States, a person who passes the evaluation, or receives a certain rating, may be qualified. The provider should speak with the organization overseeing the evaluation system to ensure that this is the case.

It is important for treatment providers to understand the parameters within which interpreters work. If an assignment (e.g., interpreting for a detoxification program) is 2 hours or less, an interpreter will usually take the assignment alone. He will probably need a break at some point during the 2 hours, however. Interpreting is taxing, and an interpreter's effectiveness diminishes over time. Well-placed breaks or hiring two interpreters will greatly reduce such fatigue and reduced performance.

Treatment programs may have deaf clients who do not use sign language. In this case, a program may need to get an oral interpreter (who mouths the words that people are saying) or Computer Assisted Realtime Transcription (CART) services. A CART reporter types everything that is said into a computer system, which a deaf person then reads on a monitor or laptop screen. Some individuals who are deaf or hard of hearing may request an assistive listening device to amplify sound. The client who is deaf can provide advice to the program and should be provided the type of device he asks for. The State agency for people who are deaf or the State VR agency should know where to obtain these devices.

Communications with people with cognitive disabilities

Programs must be prepared to adapt basic treatment modalities for individuals with impaired communication (receptive and expressive), reading, or writing skills. The use of picture books, comic books, illustrated "flash cards," art therapy techniques, and audio and videotapes may help resolve some of these communication barriers.

Individuals with TBI may have decreased comprehension of both written and oral information, or may have difficulties speaking. In other cases, these abilities may be intact but social cognition is impaired, leaving those people functionally communicative and literate, but without the requisite judgment and social interaction skills to communicate meaningfully or appropriately with clinicians and peers.

People with *aphasia* lose the ability to convey and comprehend oral or written information. These individuals may be able to think clearly but may not be able to form their thoughts into coherent sentences without a struggle. In some cases, this condition can vary from day to day, causing counselors to suspect willful noncompliance or a mental/emotional problem unrelated to language comprehension.

Cognitive disabilities may limit people's understanding of basic concepts of treatment. Individuals with developmental disabilities may not have acquired abstract thought skills, and dealing with abstract concepts such as admitting their powerlessness over alcohol can be daunting. Those with learning disabilities may have trouble processing and using abstract information. Many will have limited vocabularies. And many individuals with a variety of disabilities—not necessarily cognitive

ones—have poor educational achievement due to negative school experiences. Bad experiences in school are also predictors of later substance use disorders (Jessor and Jessor, 1977).

Architectural Barriers

Physical barriers include the absence of elevators or ramps, narrow hallways, poor lighting, wall telephones too high for people in wheelchairs, deep pile carpets that interfere with wheelchairs or crutches, conventional doorknobs that impede access to people with limited manual dexterity, or even a lack of transportation from the property's boundaries (where public transportation may drop off a person) to the facility's entrance. Programs should consider other types of modifications as well in order to make their buildings safer for all participants.

A person who is blind or visually impaired can typically move safely within an environment once it becomes familiar. The treatment provider should early on give clients who are blind a complete orientation to the facility. Signage to accommodate people who are blind and visually impaired is widely available and includes signs and elevator settings that are properly color contrasted or have raised Braille words and numbers. In addition, loose rugs, wall-mounted fire extinguishers, and lighting that is too bright or too dim can create mobility problems for individuals who are visually impaired.

When barriers cannot readily be removed, a program must find alternate methods to make its services available. A program that offers counseling in an upstairs room must offer counseling downstairs when needed, if it is not able to add a ramp or elevator. If an onsite adjustment cannot be made, an outpatient program must find an alternate site where it can deliver the same level of care it provides at its nonaccessible site. A residential program may find it necessary to make an appropriate referral as a temporary solution, while it takes the steps necessary to change its facilities for future clients.

Mainstreaming Versus Specialized Services

In general, it is beneficial and feasible to integrate people with disabilities into already existing community-based services used by other individuals recovering from substance use disorders (a process known as *mainstreaming*). However, there are a number of exceptions to this rule. In instances where a legitimate, documented reason exists, specialized services may be necessary.

People who are deaf and identify with Deaf Culture will usually prefer specialized treatment programs (see below). In addition, clients who have severe psychiatric disorders will benefit from specialized services that understand their medication and behavioral issues. People with mental retardation may find it easier to understand and participate in discussions that involve others with similar disabilities. They do not have to channel all their energy into "passing as normal" and are less ashamed to ask questions. Some clinicians find that even people with mild and borderline mental retardation, and with limited or no reading abilities, prefer to be placed with other nonreaders. Other disability conditions that may warrant some stand-alone services include TBI, spinal cord injury, or severe or multiple disabilities.

In some situations, however, grouping people with similar disabilities may be counterproductive. For example, persons who are grouped by disability may try to ignore the larger treatment population, or they may be at widely dissimilar stages of acceptance or adaptation to their disabilities. Depending on the personalities of the individuals involved, one person may keep another from going forward in treatment. While grouping generally

can produce positive outcomes, it is an adaptation that should be monitored once established.

Ideally, stand-alone services should be offered to an individual with a coexisting disability in concert with other community supports, thereby increasing the depth of the recovery plan and making the transition to sober community living more logistically possible. Such community supports could be attending an outpatient chemical dependency program in an area of the town where the client lives, becoming enrolled in vocational rehabilitation, attending support group meetings for head injury, or enrolling in a community college developmental English program.

Deaf and Hard of Hearing

Many members of the Deaf Community benefit from specialized services, which generally are better equipped to handle specific cultural, language, and communications issues that may arise. People who are deaf or hard of hearing and use sign language tend to identify themselves as part of a deaf community. Many will prefer to be served by programs that specifically address their needs and whose staff is fluent in sign language. Unlike many other people with disabilities, people who are deaf often do not identify with a medical model of disability and instead embrace a cultural model that emphasizes their abilities within the Deaf Community and their own language and values.

Most people who are deaf seeking substance use disorder treatment prefer segregated programs to mainstreamed programs. This allows clients who are deaf to participate in a group with deaf peers and a counselor who is fluent in sign language. Direct communication will facilitate greater participation by clients who are deaf than communication through an interpreter. Such a group provides an environment of peers who share similar life experiences and a common language, generally considered important for the recovery process.

Yet having a group that is all deaf is not realistic for most programs. It is more likely that, on occasion, there will be only one client who is deaf in a program, and the rest of the clients will be able to hear. In this case, the program will need to hire one or more sign language interpreters to facilitate comprehensive communication among the client who is deaf, hearing clients, and hearing staff. In some instances, the program may want to refer the person to a specialized program serving people who are deaf and hard of hearing. If a sign language interpreter is not available, the leader of the group may try to communicate with the person through pencil and paper, trying to explain some of the issues. Without the presence of the interpreter, however, the individual who is deaf will miss much of the information shared during a therapeutic group.

Some individuals who are late-deafened or hard of hearing do not use sign language, did not grow up with other people who are deaf, and do not identify with Deaf Culture. This population is actually larger than the population who uses sign language (Minnesota Chemical Dependency Treatment Program for Deaf and Hard of Hearing Individuals, 1996). These individuals will generally prefer to be served by programs for the general population alongside clients who can hear. The types of accommodations they need will differ from what is needed to effectively treat clients who identify with Deaf Culture. These accommodations will usually consist of the use of devices either to amplify sound or to print what individuals in the program are saying. These people have grown up using English as a primary language and do not have the second language issues that are common to individuals who are deaf whose primary language is ASL.

Working With People With Disabilities

A significant number of the people currently seeking treatment for substance use disorders also have a physical, cognitive, sensory, or affective disability. Many others are or believe they are unable to access the treatment they desperately need, often because of the double stigma of having a substance use disorder and a coexisting disability. This TIP provides simple, practical guidelines to help treatment professionals provide services for people with coexisting disabilities, thereby improving the quality of treatment for a large number of persons whose needs are not being met. The TIP is organized to allow treatment providers to find information pertinent to clients who may have a particular disability. Even though these categories of disabilities are often artificial distinctions, this system of organization gives treatment professionals a baseline from which to modify treatment on a case-by-case basis for their clients with coexisting disabilities.

The TIP also aims to educate providers about the needs common to most (if not all) people with disabilities and the legal, ethical, and practical reasons to accommodate this significant client population. Information is provided concerning screening for the physical and cognitive disabilities of those seeking treatment (in Chapter 2), how treatment can be modified to work better for people with disabilities (in Chapter 3), establishing linkages with other types of agencies and programs (in Chapter 4), modifications to the program that might need to take place at the administrative level (in Chapter 5), and ADA compliance (see Appendix D).

Many treatment providers have been reluctant to take on clients with disabilities because they assume difficulties that may not exist. The less one understands disabilities and their corresponding functional limitations, the more daunting accommodation appears. A useful parallel is the beginning of the acquired immunodeficiency syndrome (AIDS) epidemic in the 1980s, when many health care workers were afraid to treat patients with human immunodeficiency virus (HIV) and AIDS (a population also covered by the ADA). In that case, education and hands-on experience with AIDS patients countered the widespread apprehension better than anything else. Similarly, more information such as that provided in this TIP and the inclusion of clients with disabilities in treatment programs will help reduce barriers to treatment discussed above.

The process of education will help treatment providers discover that people with disabilities are more like than unlike other clients, and that they have already been treating people with disabilities without knowing it. The presence of people with disabilities in a treatment group can benefit all clients. Appropriate accommodation of a person with a disability fosters cooperation at the same time it enriches group diversity. By better serving people with identified disabilities, the treatment provider will improve care for a great many other clients as well, as providers learn to tailor treatment to each client's individual needs.

2 Screening Issues

Physical, sensory, and cognitive disabilities affect far more clients than many treatment providers realize. Because so many people in treatment programs for substance use disorders have coexisting disabilities, the Consensus Panel recommends that every new client be screened for disabilities. In the screening process, each client's level of ability in various areas of functioning should be evaluated. The screening described here is not and should not be seen as an additional task to be performed only with people who have an obvious physical or cognitive disability.

Persons with disabilities also may require modifications in the way treatment personnel perform screening and assessment for substance use disorders. As with any stage of treatment, providers will need to make accommodations for people with disabilities in their screening procedures. Because both these forms of screening will occur at roughly the same time, both will be discussed below.

"Disability Etiquette"

It is important that providers be sensitive to the feelings as well as the needs of people with disabilities from their first contact onward. Providers who have never worked with someone with an obvious disability may feel awkward, unsure of what to say, or what help to offer. Sensitivity and openness will help ease this discomfort, as will the following guidelines.

In planning and providing treatment to people with disabilities, the importance of asking questions cannot be overemphasized. "Disability etiquette" involves maintaining an awareness of intrusion into an individual's personal space. Asking before rendering any service is a basic principle. "May I help?" should be followed by "How may I help?" For example, if a person is struggling to put a wheelchair into a car, it is important to first ask if help is needed and then to ask how the wheelchair should be placed in the car so that the person can later remove the wheelchair unassisted.

Some providers may feel embarrassed to ask certain questions or may worry about giving offense, even when the answers are critical to the treatment planning process. It may be helpful to preface such questions by requesting permission to ask them. "May I ask you about..." or "It would help me to know more about..." are ways of beginning to ask more direct questions. It is, however, important for staff members to be able to be honest and acknowledge that they may not know the appropriate way to ask a question.

Although resources regarding disability etiquette are available from organizations such as Easter Seals and the American Foundation for the Blind, it is always best to ask each person what he wants, thus ensuring that cultural, gender, and personal preferences are met. (See Appendix C for information on how to refer to people with disabilities.)

People With Sensory Disabilities

The majority of people who are blind use a cane; fewer use guide dogs. Either way, people who are blind or visually impaired will require assistance in orienting themselves to a new environment. Treatment providers should try to describe or guide a person through a new environment. Instead of stepping back and allowing the person to fumble, the counselor should offer "sighted guide" assistance, during which the person who is blind holds the sighted person's arm just above the elbow and they walk in tandem. Pulling a person by his arm is not appropriate.

People who are blind live in a more touch-oriented world than the sighted population. It is acceptable for the counselor to put the blind person's hand on the back of the chair she is to use. A service animal, however, should not be distracted from its job; the animal should not be touched or petted, nor should one even ask permission to do so.

Word use is important. The counselor must use more descriptive and detailed language and strive to avoid phases like "over there" or "like this." There is no need to avoid words like "see" and "look"—they are part of everyone's daily language.

Finally, more than 80 percent of people considered "blind" have some residual vision. This remaining vision is typically light- or glare-sensitive. It is helpful to ask if the lighting in the current environment is uncomfortable. Figure 3-6 in the next chapter presents these and other suggestions for working with people who are blind in the form of an easy-to-follow list of suggestions.

Communication is the key issue when dealing with individuals who are deaf and hard of hearing. Regardless of the model of communication used by the person who is deaf or hard of hearing, the visual aspect of communication will be important. Therefore, it is important to look directly at the person when communicating so he can see facial expressions and has the option of lip-reading. When interviewing a person who is deaf with an interpreter, it is still important to look directly at the client. Speak directly to him just as if there was no interpreter present.

People With Physical Disabilities

Persons with disabilities that limit their mobility can encounter situations like sidewalks without curb cuts or front doors that cannot be opened from a wheelchair. They are understandably annoyed if they are stymied by these barriers and then hear those responsible for the facility explain, "We hardly ever get someone with a wheelchair here." Providers should not assume that someone in a wheelchair is unusually resistant to treatment just because she expresses anger at not being able to enter the facility through the same entrance or use the same restroom as other clients.

People who use wheelchairs often come to regard the chair as an extension of themselves, and touching the chair may be offensive to them. Never take control of the wheelchair or touch any other adaptive equipment without permission.

Screening for Disabilities

Treatment providers are not expected to become experts in disabilities or to diagnose disabilities themselves. However, functional limitations and symptoms of disability are likely to become apparent as clients with disabilities participate in treatment, and a provider should recognize certain signs and symptoms.

It is the level of abilities and of the functioning of the individual—not the simple determination of whether a disability exists—that must be assessed if screening is to lead to an effective treatment plan. In situations where a diagnosis of disability is needed (e.g., to qualify for special services), treatment providers should refer the client to a disabilities services

professional. State vocational rehabilitation (VR) programs may be a good source for referral.

Functional limitations associated with a disability, whether apparent or not, can undermine treatment if they are not recognized and addressed. For example, a person's lack of progress in treatment may be mistakenly attributed to a lack of motivation, when in reality a functional limitation, such as an inability to read, is impeding her ability to understand or participate in treatment. Such an individual may seem indifferent to achieving her treatment goals, when she is actually having difficulty processing or retaining information.

Treatment providers should be careful not to make determinations about a person's disability when they are not qualified to do so. Initial screening is encouraged, but an expert on the particular disability should conduct any further assessment. Of course if a client is being referred from a disabilities expert, staff should ask for a full evaluation that includes specific client strengths and weaknesses.

Initial Screening

Through the screening process, the provider can begin to understand the circumstances in a client's life that are likely to have a bearing on treatment. All such circumstances, whether or not they are disabilities, should be incorporated into the treatment plan.

Questions relating to disabilities can and should be incorporated as seamlessly as possible into a comprehensive screen, rather than treated as an altogether separate subject. After discussion of the substance use disorder, the interviewer can bring up visibly obvious impairments, such as those requiring the use of a wheelchair or cane. The questions can be framed by the program's desire to respond to individual needs: "Do you need any accommodations to participate in this program?" This question should be posed to everyone, not only to those the interviewer thinks have a disability.

The possibility of hidden impairments can be explored subtly during the conversation. For example, during a routine medical history, a question about past hospitalizations can elicit information about a previous brain or head injury, thus alerting the interviewer to the possibility of traumatic brain injury (TBI). Similarly, a client's answers to routine questions about past and current medications may point to the possibility of cognitive or affective impairments (see Case Study below). A client's referrals from other service providers such as VR services can also offer insights into less obvious impairments.

Setting always influences the screening process; this is especially true when testing or interviewing for disabilities. An individual's problems with mobility, for example, may make it necessary for the interviewer to travel to his home, where there may be distractions of children or other family members. However, a person might not be willing to speak openly in front of other family members, even if they already know about her disabilities. Wherever the interview takes place, it is important to create a sense of privacy in talking with the client.

Figure 2-1 presents a basic screening instrument for identifying impairments and functional limitations that can be handed to a client preceding an interview. The text can be used verbatim (with the instructions given at the top of the figure) as a form all clients would receive before a screening and assessment session. In the answers to questions such as these, the interviewer should be looking for things such as the history and symptoms of diseases or disorders that can provide clues to impairments and disabilities. If the questions and discussions based on the screen indicate an

Figure 2-1
Educational and Health Survey

Please answer the following questions keeping in mind that we are trying to get to know you better and to identify areas that may create difficulty for you in treatment if we don't know about them.

1. Do you have a disability or have you ever been told that you have a disability?
   ___Yes ___No
2. Are you currently under the care of a doctor or other medical care professional?
   ___Yes ___No
3. Do you take medications?
   ___Yes ___No
4. Do you have difficulty hearing in group settings (e.g., theaters, classrooms, family dinners)?
   ___Yes ___No
5. Do you frequently need people to repeat what they have said to you?
   ___Yes ___No
6. Have people complained that you don't hear or don't listen to them?
   ___Yes ___No
7. Do you wear glasses or contact lenses?
   ___Yes ___No
8. Do you have difficulty seeing things that are far away or very close?
   ___Yes ___No
9. Do you have frequent eye pain or headaches?
   ___Yes ___No
10. Have you ever hit your head and lost consciousness?
    ___Yes ___No
11. Have you ever received health or disability benefits?
    ___Yes ___No
12. Have you ever been unemployed for a long period of time?
    ___Yes ___No
13. Have you ever been fired from a job, asked to leave a job, or passed over for a promotion?
    ___Yes ___No
14. Did you ever have special classes or tutoring in school?
    ___Yes ___No
15. In a school or work setting, do you like to learn or learn best by
    ___Listening to someone talk
    ___Watching someone perform a task
    ___Reading on your own
    ___Performing tasks yourself
    ___Discussing things with another person
    ___Discussing things with a group of people

Figure 2-1 (continued)

16. **Have you had problems or difficulty with any of the following?**
    - ___ Getting your point across to others
    - ___ Sitting still
    - ___ Focusing on the task at hand for more than several minutes at a time
    - ___ Understanding the point that others are making to you or what others are saying to you
    - ___ Communicating your feelings or thoughts to others
17. Have you ever had problems with or been bothered by any of the following?
    - ___ Controlling anger
    - ___ Remembering things
    - ___ Following instructions (verbal, written, or demonstrated)
    - ___ Concentrating
    - ___ Becoming tired easily
    - ___ Getting along with others
18. Have you ever had problems or been bothered by any of the following?
    - ___ Depression
    - ___ Anxiety
    - ___ Forgetfulness
    - ___ Sleep problems
    - ___ Nervousness
    - ___ Muscle tension or soreness
    - ___ Uncontrolled worry
    - ___ Excessive worry
    - ___ Irritability
    - ___ Restlessness (feeling on edge)
    - ___ Mind "going blank"
    - ___ Rapid heart rate
    - ___ Pounding in chest
    - ___ Heart burn or stomach pain
    - ___ Uncontrolled feelings of happiness or euphoria

impairment, the client should be referred to a disabilities expert for a more in-depth screening.

Figure 2-2 presents the questions from Figure 2-1 in the manner they might be asked during a spoken (or signed) interview, with the numbers of the relevant questions provided in parentheses. This figure also provides further questions that might be asked and ideas for how the information gained in the interview could be used in followup treatment planning.

Throughout the screening interview, it is important for the screener to pay attention to the individual's affect and behavior in order to pick up on possible cognitive or affective impairments. Screening for psychiatric disorders is discussed in TIP 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (CSAT, 1994).

Figure 2-2
Impairment and Functional Limitation Screen

Questions	Further Questions	Followup Treatment
Do you have a disability, or have you ever been told that you have one? (1)	It may be useful to ask what a typical day is like to gain a better understanding of how these accommodations affect the person's daily life. Ask client to specifically describe the activities and events of the day. Her answer may indicate problems in functional areas such as self-care, learning style, mobility requirements, or reveal her participation in a work program. If the person uses an assistive device, inquire how long it has been used.	Refer to vocational rehabilitation. Consult with disability professionals.
Are you currently under the care of a doctor or other medical care professional? (2)	Inquire as to how a condition affects the person's daily life (e.g., what accommodations and precautions he takes).	Consult and communicate with physician. Obtain medical records.
Are you taking any medications (prescribed or over-the-counter)? (3)	If the client takes medications, does she understand what they are being taken for? What side effects from medications has she experienced? A recent medication history should be taken.	Provide medication education. Use charting or a pill case to organize medications and ensure proper use. Remind client when she should take medication. Use timers or pagers to remind client of when to take medication. Set up appointment for medication check with physician.
Do you have difficulty hearing in group settings (e.g., theaters, classrooms, family dinners)? Do you frequently need people to repeat what they've said to you? Have people complained that you don't hear or don't listen to them? (4–6)	Ask if client has had his hearing tested recently (or ever). Look for nonverbal signals that he is having difficulty hearing (e.g., looking at lips instead of eyes, thinking a long time before answering questions, ignoring questions, not directly answering questions). Some attempt should be made to determine if problems are attentional in nature rather than due to a hearing impairment.	Administer hearing test and language or communication test. Have client sit in front during classroom type sessions. Place client nearer to the speakers when movies or tapes are being used. Have sessions with client in the room with the best acoustics. Meet with client after group sessions to discuss what occurred as a way to determine whether he heard everything that was said. Arrange the room so that outside noise is minimal and so that clients can all see each other. Develop a cueing system to let client know when he is being spoken to and so client can signal when he cannot hear. Repeat the points or questions of group members often. Use an interpreter when appropriate. Use a microphone in a large group setting. Use other assistive devices like a radio amplification system. Frequently check in with client to make certain that he is following what is being said.

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Figure 2-2 (continued)

Questions	Further Questions	Followup Treatment
Have you ever hit your head and lost consciousness? (10)	Further investigate any occurrences even if the client was not sure whether he sustained an injury (sometimes issues of inebriation and the loss of consciousness due to trauma are mixed together). Ask client if he has ever been in a car accident or a fight. Ask about the length of time unconscious, the circumstances surrounding the accident, whether alcohol or drugs were involved, and any changes in functioning dating from the time of the injury.	Obtain results of any previous neuropsychological exam. If none has been done, arrange to have one administered (if funds are available). Consult with a psychologist about the neuropsychological test results and about possible accommodations. Administer a short, simple memory test.
Have you ever received health or disability benefits? (11)	Ask client why she received these benefits and if that influenced her work or search for a job.	Request records. Consult with client's case manager or benefits coordinator. Help client to get assistance that she is entitled to.
Have you ever been unemployed for a long period of time? Have you ever been fired from a job, asked to leave a job, or been passed over for promotion? (12–13)	Ask if the client feels unsatisfied with the work he's been able to find. Ask if he's ever had a job where he didn't understand the tasks he was asked to perform or felt unable to perform them. Ask how he obtained his most recent work, and whether he has ever been involved in a vocational rehabilitation program.	Obtain vocational rehabilitation records if applicable. Refer to vocational rehabilitation. Use self-administered interest inventories. Design assignments and treatment goals relating to employment and/or vocational rehabilitation.
Did you ever have special classes or tutoring in school? (14)	Ask whether the person has ever had a past diagnosis of a learning disability. Ask questions such as, "Is English your first language? Can you read English? Do you like to read? What do you like to read? How often do you read and for how long generally?" For a client who is blind, ask, "How do you read? Audiotapes? Braille? Any other method?" Unless the person states that she cannot read, find an opportunity—later in the interview, so that it is not connected with the question—to have her read something aloud. This should be something brief, such as a sentence in a release statement or a standardized screening questionnaire for substance use.	Use audio- and/or videotapes. Use murals, art activities, role-playing, etc., instead of written assignments. Use feelings chart or other picture tools during session. Take frequent breaks. Confer with client periodically to find out if she is understanding material. Arrange for extra help/tutoring from peers or counselor.
In a school or work setting, do you like to learn or learn best by listening to someone talk, watching someone perform a task, reading on your own, performing tasks yourself, discussing things with another person, discussing things with a group of people? (15)	While many clients will not be able to answer this question very easily, those that can will be able to provide information that can prove to be very valuable in developing a treatment plan. Ask for details concerning positive and negative learning experiences. Find out if any accommodations have been made in the past in order to help the client learn most effectively.	Attempt to utilize client's preferred means of learning as much as possible.

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Figure 2-2 (continued)

Questions	Further Questions	Followup Treatment
Do you ever have difficulty sitting still, focusing on a task for more than several minutes, understanding what people are saying to you, or communicating your thoughts and feelings to others? (16)	Anything but an unqualified "no" should be followed up since it could point to a possible attention deficit. Ask under what circumstances the person has had these problems and what kinds of distractions he has had, such as environmental (noise) or physical (pain). Observe whether he is able to sit still during the interview. The sensory aspects of understanding speech need to be addressed separately (see above).	Take frequent breaks. Allow client to stand or alternate standing and sitting. Use shorter sessions. Have an agenda for each session which clients can follow. Stagger client participation during a session to keep him involved (for example, every ten minutes after each key point or after each group member shares). Use cues to let client know when he is getting off track. Use other refocusing techniques like summarizing what has happened or using quick response activities ("every one tell me how you are feeling right now"). Limit the number of key points per session. Alternate types of activities throughout the session.
Do you ever have problems controlling your anger, remembering things, following instructions (either verbal, written, or demonstrated), concentrating, becoming tired easily, or getting along with others? (17)	Ask about friendships and relationships with others; find out if the client has problems with friends, family, or being a "loner." Ask if she is getting tired or having trouble concentrating during the interview.	Use relaxation techniques. Use memory books. Provide client with a schedule that is in short increments. Adhere to regular scheduling. Give client as much notice (and reminders) as possible if schedule will change. Use written and/or pictorial instructions. Use audio and/or video instructions. Involve the client in role-playing. Use mock sessions to prepare client for what will happen. Arrange field trips. Use cues to keep client on track. Take frequent breaks. Determine client's most alert times and attempt to schedule key activities during those times. Begin treatment plan utilizing individual counseling only and work towards group involvement. Allow client to observe group before engaging. Include anger management activities in treatment plan. Expect to repeat key points often.
Have you ever been bothered by any of the following: depression, anxiety, forgetfulness, sleep problems, nervousness, muscle tension or soreness, uncontrolled worry, excessive worry, irritability, restlessness (feeling on edge), mind "going blank," rapid heart beat, pounding in chest, heartburn or stomach pain, uncontrolled feelings of happiness, or euphoria? (18)	Ask the client if he is in or has ever been in counseling. If he has, ask how often he visited a mental health professional and what problems were most often discussed. Find out if the client currently has or has ever had any suicidal ideation. Ask what his normal sleeping and eating patterns are, and what a typical day is like. Look to see if he appears sad or depressed, and if his grooming is adequate.	Obtain medical records or mental health records if possible. Refer for mental health assessment. Use relaxation techniques. Use recreation therapy. Refer for a physical therapy or occupational therapy assessment. Refer for a medication check. Have client keep a journal or log about his symptoms to see if there is a pattern to them. Use memory book or other memory techniques. Have client practice memorizing short slogans or phrases.

Screening for sensory disabilities

A treatment provider need not conduct an assessment of hearing loss when working with people who are deaf or hard of hearing. The provider should, however, note the individual's apparent adjustment to the hearing loss and psychosocial factors related to it. This information could be used in determining the

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type of program to which to refer the client (a mainstreamed program or an all-deaf program) and could be useful to the treatment provider in developing a treatment plan. Clinicians who conduct screenings should consult with a professional who is experienced in working with people who are deaf and can assist the clinician in developing an appropriate referral to treatment.

Background information to consider when screening an individual who is deaf or hard of hearing includes the following:

- Is the family of the client deaf or hearing?
- What is the nature of the client's relationship with family members?
- What is the extent of communication between the client and significant family members?
- What is the communication mode used by the client? If signing, what is the style used?
- What type of school program(s) did the client attend? How did he feel about the program and his experiences there?
- Is the client's primary peer group deaf or hearing? If hearing, what is the extent of communication with these peers (how fluent)?
- How does the individual feel about and cope with her hearing loss?

If a client uses sign language as her primary mode of communication, attended a residential school for the deaf, or socializes primarily with people who are deaf, it is likely that an all-deaf program is most appropriate for him. On the other hand, if she does not use sign language, grew up attending public schools without support services, and has no deaf peers, a mainstreamed program may better meet her needs.

Screening for cognitive and affective disabilities

Some cognitive impairments, while not readily apparent, may be revealed by subtle behavioral cues. For instance, difficulty in attending to the questions being asked or fidgeting and restlessness during the interview may indicate an attention disorder.

Memory problems, such as those resulting from TBI, may also be hard to detect initially. A person might be quite conversationally skilled and appear to be comprehending a vast amount of new information but might not retain the information even until the following day. Given the significance of retaining treatment information, memory difficulties need to be detected early so that a more in-depth assessment can be conducted and treatment recommendations can be made.

A person's problem-solving and reasoning abilities may be impaired by head trauma and substance use. While this functional limitation can greatly affect decision making in high-risk situations, it might not emerge as problematic while the client is responding to questions about his personal background in a well-rehearsed fashion. For this reason, it may be important for the clinician to informally assess reasoning and problem solving with more novel questioning or a brief screening tool that does not solely target the individual's personal social history. One way to screen self-care and problem-solving capacities informally is by asking a person to complete some simple activities such as writing a check or performing a practical math problem.

Substance use disorders may elicit behaviors that could be mistaken for mental health concerns. For example, many substance-using clients display paranoid behaviors that may take time to dissipate even after detoxification. Looking at these cues as potential signals, rather than drawing conclusions from them, will help the interviewer avoid making false presumptions.

Interviewers also need to be aware that substance use disorders can obscure a disability. The use of cocaine and crack can mask clinical depression, and some individuals with severe,

chronic depression may self-medicate with crack or cocaine. Upon admission to a substance use disorder treatment facility, these individuals appear appropriate in affect. However, after detoxification, they plunge into a deep, intractable depression, requiring psychiatric intervention and medication. Individuals with mental retardation or developmental disabilities often use marijuana or alcohol to mask their disability—it is difficult to discern a drunk or high person with developmental disabilities from a drunk or high person without such disabilities.

Conversing with an individual with a cognitive disability about her disability can provide other information relevant to treatment. For example, asking someone how he became cognitively disabled may reveal a history of physical abuse, accidents, or illnesses resulting in head injuries in childhood. Asking how old someone was when she first realized she had a disability and what that felt like can reveal suicidal ideation in childhood and untreated pain over the disability, problems that may contribute to a substance use disorder in later life.

From Screening to Treatment

One of the challenges substance use disorder treatment programs face in providing services to people with disabilities is determining what the program can offer these clients to best meet their needs. The screening process can help to identify those areas where linkages with other services and agencies are needed. Changes to the program and its facilities may also be needed.

The aim of the initial screening for disability-related considerations is not a diagnosis, but rather a pragmatic exploration of the potential barriers to treatment that may arise from a disability and its associated functional limitations. Individuals entering chemical dependency treatment do not always benefit from learning new, potentially stigmatizing terms that apply to them, but they may benefit from modifications to the treatment process. Which is not to say that staff and clients should avoid talking about disabilities, but that it is more important to focus on necessary modifications to treatment than on a specific label. Additionally, treatment personnel are unlikely to be qualified to make disability diagnoses; however, in a practical sense, they are likely to be more skilled than they realize in adjusting treatment approaches based on the needs of their clients.

Questions used to screen for the presence of disabilities can be asked verbally, or the client can fill out the written survey provided in Figure 2-1 before an interview begins. After the screening it may be useful to draw up a profile of the client that presents the person's strengths and needs, along with recommendations to address those needs. This profile can be drawn up as a chart listing the seven areas of functional limitations described in Chapter 1. Each of the seven areas of functional limitation used in this screening (self-care, mobility, communications, learning, problem solving, social skills, and executive functions) presents specific considerations that may be identified in the screening interview. In the example below, questions from Figure 2-1 are applied in an actual interview; an accompanying profile, for a person with TBI, is depicted in Figure 2-3. A discussion of how the information gathered can be applied in treatment planning follows.

Case Study

"John," a 26-year-old white male, was referred from a local criminal justice agency after an arrest for driving under the influence (DUI). A high-school graduate, he lived with his mother and had held a series of entry-level jobs, none for more than 8 months. He had no obvious

disabilities and stated that he is at the program because he "got into trouble." The screening questions presented below reflect a portion of a lengthier interview; John's answers to the questions will assist providers in planning his treatment program.

Q: Do you feel you have a disability, or has anyone ever told you that you have one?

A: No, nothing like that.

Q: Have you ever had to stay in a hospital overnight, or gone to an emergency room for any reason?

A: I've had some falls, and once I broke my arm. I went to the emergency room. But I never had to stay overnight.

Q: Have you ever seen a doctor for a long period of time, more frequently than just one visit or for routine check-ups?

A: Yes when I was in grade school.

Q: What was going on for you that you needed to see the doctor so often?

A: I'm not sure. I think I was overactive. I was on some kind of medicine.

Q: Do you know what kind of medication it was?

A: It was "rid-lin" [Ritalin] or something like that.

Q: Were you ever diagnosed with a learning disorder?

A: I don't think so.

Q: Were you ever in special education classes in school or did you receive any kind of tutoring?

A: I had some tutoring for math.

Q: Have you ever been given a hearing test?

A: Yeah. When I was in school they did hearing tests. I always passed them with flying colors. I don't have any hearing problems.

Q: Do you ever have to ask people to repeat what they're saying? Or has anyone ever complained to you that you don't listen?

A: Yeah, well my boss at work always says that I don't listen. And my teachers at school used to tell my mother that I don't hear what people are saying to me.

Q: Did you ever need to wear glasses?

A: No.

Q: When was the last time that your eyes were checked?

A: Oh, about 2 years ago. I was having some problems at work because they have really bright lights in the building. That would give me a headache sometimes. The eye doctor said that my eyes looked good. I guess I just don't like bright lights.

Q: Have you ever been hit on the head or had any blows to the head?

A: Now that you mention it, there was this one time in high school after football practice. Some of us were fooling around and I got into a fight. I don't know what happened. But I had to get some stitches and I had a headache for a few days.

Q: Did you lose consciousness?

A: I don't know. I guess there were some things I don't remember that people told me about later.

Q: What's the first thing you remember after the fight?

A: Riding in the ambulance.

Q: What did they do at the hospital?

A: I got some stitches in my forehead and they kept me around for a while to keep an eye on me.

Q: Did you notice any changes in your abilities since then?

A: No, not really.

Q: Have you had problems with bad or frequent headaches since the fight?

A: I guess sometimes I have headaches.

Q: Have you ever talked to a doctor about them?

A: No, not really.

[This is a problem that may need to be followed up with a physician visit. If neuropsychological testing was never done after

the accident, it should be performed now if funds are available.]

Q: Have you ever received benefits of any kind? Like from a government agency?

A: No.

Q: Let's talk about your work history for a while. How many jobs have you had in the past three years?

A: Oh, about four or five.

Q: What was the longest job that you held?

A: Last year I worked for 8 months as a grocer's assistant. I quit because the boss was getting on my case. I don't think he liked me very much.

Q: Why do you think that?

A: Well, he would yell at me or tell me that I didn't do my job right. I should have been given a better job there, but he would say that I couldn't figure out how to do the job I had. He said I was forgetful.

Q: Do you think that you are forgetful?

A: Yeah, I guess so. I just sometimes forget things at work. There's too much to remember all at once.

Q: How were you taught your job?

A: Well, I followed this guy around and did what he told me to.

Q: Did that work? Do you feel that you learned the job?

A: It was OK when we worked together. Then they gave me a big list of stuff and I was supposed to just follow the list, but it didn't make sense.

Q: Were you able to read the list OK?

A: I guess some of it I didn't understand.

Q: Were you able to ask someone to explain the tasks required?

A: No, I just kind of figured it out. I don't like to ask a lot of questions. People don't always understand what I'm asking about anyway.

Q: Do you ever have trouble controlling your anger?

A: Maybe when I'm drinking.

Q: Do you ever feel anxious or on edge?

A: Sometimes. When I'm bored.

Q: How about feeling depressed? Or really happy for no reason?

A: No.

Q: Is English your first language? Did you speak any other language when you were growing up?

A: No, I only speak English.

Q: Tell me about your reading habits. What kind of stuff do you like to read? How often do you read?

A: I don't really like to read. I mostly read the comics. Stuff like that. [The screener suspects a reading problem from this answer. Later on in the interview the client is asked to read a simple sentence from a Release of Information form, and he labors over it in a halting manner.]

Q: Do you ever have trouble paying attention or concentrating on things?

A: With things I like, I don't have a problem, no.

Q: What kinds of things interest you and hold your attention?

A: Sports and TV shows I like—mostly comedies.

[In the last portion of the interview, the screener has noticed that the client has been preoccupied; he keeps looking out the window, and the interviewer has had to repeat some questions.]

The results of this screening interview and how they pertain to the identification of areas in which John may have impairments and disabilities are presented in Figure 2-3. The interview with John and the accompanying

Figure 2-3
Profile of "John"

Functional Area	Strengths	Needs	Recommended Followup
Self-Care			
Eating	OK		
Grooming	Well groomed		
Bathing	OK		
Dressing	OK		
Bowel and bladder management	OK		
Mobility			
Positioning	OK		
Walking, with or without assistive devices (e.g., walker, cane)	OK		
Use of wheelchair	No		
Use of stairs	OK		
Ability to operate motor vehicle		License suspended due to DUI	
Use of public transportation (or other access to transportation)			Check on the availability of transportation and the need for explicit directions to treatment site
Communication			
Reading		Apparent reading problem	Request school records; records should also indicate whether or not he took special education classes, received a regular high school diploma, or was diagnosed with a learning disability

profile may raise as many questions as they answer. However, after the interview the major issues become clearer, and the next steps are more evident. John may have had one or more sources of compromise to his mental abilities. Regardless of the source, at this point the screening has raised questions about his reading, learning ability, problem-solving

Figure 2-3 (continued)

Functional Area	Strengths	Needs	Recommended Followup
■ Writing			Writing skills need to be determined, but requirements are minimal in program
■ Speaking	Well-spoken		
■ Listening			Listening ability may be limited by attention problems
Learning			
■ Attention		Attention problems	Ritalin use in childhood may indicate the need for a referral to a psychiatrist for further evaluation
■ Comprehension	Comprehension appears to be good		
■ Retention and Application			May need formal assessment of retention and application abilities
Problem-Solving			
■ Awareness and recognition of problem		Statement that reason for being in treatment is he "got into trouble" may indicate lack of awareness of problem (DUI)	
■ Identification of alternatives			Screen problem-solving skills and anticipate possible consequences of various alternatives; then decide on optimal alternative
Social Skills			
■ Understanding of social mores and values	Statement that he "got into trouble" indicates awareness of social values		

Figure 2-3 (continued)

Functional Area	Strengths	Needs	Recommended Followup
■ Impulse control		DUI and story of fight indicate impulse control problem; although they may be drinking-related	Further evaluation called for since substance use can cause a lack of impulse control
■ Intimacy			Explore relationships
■ Conversational skills	Conversational skills consistent with age, etc.		
■ Empathy; ability to identify with others			Need to further explore
Executive Functions			
■ Planning and organization ■ Motivation and initiation ■ Monitoring and reviewing ■ Motivation, decision-making, disinhibition			Explore basis of sporadic work history

ability, and social skills. Additionally, executive functions as they relate to vocational capability need to be further evaluated. There are two questions the treatment provider should consider at this point:

- How will these limitations affect John's participation in our program?
- What additional information do we need to make sure he can get the maximum benefit from treatment?

The extent to which John's needs will affect participation depends on the program. His reading problems will only limit participation if written materials are a pivotal part of the program. Attention problems will be more of a difficulty in group treatment, extended sessions, or treatment that occurs at the end of the day. His possible difficulties with awareness and problem solving will be more limiting if the treatment program requires higher levels of insight and abstraction, particularly if there are not opportunities for individualized attention to assist with understanding and recognition. Finally, limitations in social skills may limit participation in a residential program or other treatment that involves significant peer interaction.

If the nature of the treatment program is such that John's needs will limit his participation, then more aggressive steps to seek additional information and assistance may be necessary. For instance, consultation with a rehabilitation psychologist might be called for to help

ascertain John's optimal learning style and ways in which problem-solving abilities and social skills can be mediated. On the other hand, if there appear to be few ways in which John's participation in the program will be hindered by his functional limitations, then treatment might be initiated with the intention that if problems emerge additional information or consultation will be sought.

Intake

Admissions Procedures

The Consensus Panel recommends an "open door" policy that states that all clients are entitled to an assessment if they are presenting with a chemical dependency problem, regardless of what other problems they may appear to have. If the proper course of treatment is not available at the facility, it is still possible to perform an assessment for substance use disorders and refer the client for treatment elsewhere.

Some treatment programs allow only 1 hour for the intake interview. Persons with certain physical or cognitive disabilities may require a longer interview, and rest periods may need to be scheduled. Flexibility should be built into interview scheduling. Some residential or inpatient treatment programs have found it effective to schedule an interview over 2 hours, before and after lunch. Facilities with in-house meal programs can offer the person a meal ticket when the intake is scheduled, which may provide an additional incentive to stay to complete the interview. In other programs, the interviewer can encourage the individual to bring a bagged lunch. For some people, the informality of a shared lunch may encourage the disclosure of issues that might not come up in a formal interview session.

Admissions procedures for people with sensory disabilities

While treatment providers should try to use qualified sign language interpreters for communicating with people who are deaf or hard of hearing, there may be times when the program is not prepared for such a client. If a person who is deaf or hard of hearing shows up unannounced at the treatment center's door, the program will need to cope as best it can. If no one at the agency knows sign language and there is no interpreter available to come in, paper and pencil is probably the best way to communicate to the person that she cannot be helped today.

Due to the wide range of reading abilities among people who are deaf, paper and pencil should never be utilized to gather detailed screening information. Written English forms and questionnaires should be interpreted into sign language for these clients. Some programs use a videotape in ASL, or with captioning to ensure understanding. The client who is deaf may have questions after watching the video, so an interpreter should be available to interpret any questions and the answers from the counselor.

If there are forms to be completed, people who are blind must have the option to complete them in the medium of their choice (Braille, large print, audiocassette, or sighted assistance). Admission to substance use disorder treatment can be a stressful process that will be made more uncomfortable by forced adherence to an uncomfortable modality. Individuals who are both deaf and blind will need to have a tactile interpreter to translate for them during the admissions process and afterward.

Admissions procedures for people with cognitive disabilities

A program should examine its written forms, from intake and screening forms to treatment plans, to determine whether they adequately address the needs of people who are cognitively

impaired. Intake forms should either be simple enough for a cognitively impaired person to understand or else someone should be available to assist the client in completing them.

It may prove useful for clients with cognitive disabilities if the informed consent form has a clause that allows the program to go to a collateral source, such as a family member or significant other, for information. (However, it should be kept in mind that information obtained from these sources may not be reliable, and that they may not have an accurate perception of a person's functional abilities.) It is a good idea to get background information from as many sources as possible, but to interview the person alone if possible. Having others present often distorts the quality of the interview.

Admissions procedures for people with physical disabilities

Persons with disabilities that affect their fine or gross motor skills may not be able to fill out self-report questionnaires because the boxes are too small; large print forms can assist persons with mobility limitations as well as some individuals with visual impairments. Computers can also be used to respond to questionnaires, as keyboards are sometimes less cumbersome than writing by hand (Moore and Siegal, 1989).

Intake Interview

A supportive, nonconfrontational intake interview is critical to engaging the client. Often, it is the pivotal meeting during which a client makes a short-term commitment to "check out" treatment. Depending on the treatment program, various approaches are used to help a client admit that he needs help in overcoming addiction. The Consensus Panel recommends that intake interviews of persons with coexisting disabilities be conducted by the most qualified staff members—those who have been specifically trained to understand their needs. The interviewer must have the skills to ask difficult questions in ways that are not offensive and maintain a good rapport with the client. Most important, such an interviewer will be more likely to detect subtle or hidden disabilities not previously identified that may make a significant difference in treatment outcome. If the intake interviewer does not have expertise or knowledge about disabilities and she knows that the individual being interviewed for admission has a particular disability, a professional who is knowledgeable about that disability should be included in the intake interview.

One of the first tasks of the interviewer is to reduce the anxiety of the client, which may be high. Many intake interviewers begin an interview by asking a very open and friendly question. Questions such as "What led you here?" or "What happened to bring you here today?" are usually nonthreatening. It is recommended that this type of question be asked initially rather than a question about the person's disability. Even when a person has an obvious disability, an initial question about it is inappropriate. However, an individual with a disability may also be very sensitive to others being uncomfortable and unwilling to talk about his disability. Thus the interviewer must judge whether it will make the client more comfortable to introduce questions about the disability during the introductory or the intermediate stage. The interviewer must remember the focus is the person, not her disability.

Intake interviews for people with cognitive disabilities

As in any interview with someone who has a cognitive disability, it is important to find the optimal setting, one that has a minimal number of distractions. The interviewer should allow for breaks in the interview and be sensitive to the client's attention span and restlessness.

Questions for people with TBI should be structured to provide concrete landmarks (e.g., "What were you doing 3 weeks before your automobile accident?"). Working backward in

time while using specific events will assist the client to structure his responses. For any person who is cognitively impaired, keep questions concrete and avoid abstract concepts.

For people with cognitive impairments, it is important to remember to ask simple questions; to repeat questions; and to ask the client to repeat back, in her own words, what's been said. The counselor may need to periodically check whether the person is understanding what is being asked. If the question is not understood it will need to be repeated in a different manner. However, it is important to not talk to people with cognitive disabilities below their own level of communication or as if they were children. They will be highly insulted, and will probably not come back.

Along those same lines, the interviewer should give specific examples to illustrate words or phrases which may be too abstract or sophisticated, such as "abstinent" or "withdrawal symptoms." Such rephrasing is appropriate for a wide range of clients—not only the cognitively disabled but also clients from different cultural backgrounds.

Some interviewers find it useful to ask a client to write a few sentences describing his activities over the past few days or weeks, or to read a sentence from the informed consent form. Some high-functioning individuals may simply never have learned how to read and write, and the interviewer should not make assumptions about a disability based on the lack of this ability.

The interviewer should end the interview by summarizing the information learned. Recognizing a person's difficulties by providing feedback is an important way to let her know that she has been understood. The interviewer should present an overview of the services the program offers that meet the client's individual needs, as well as express the program's willingness to accommodate her disability needs, in hopes of obtaining her commitment to return.

Intake interview with people with sensory disabilities

An intake interview should address the eye condition and blindness adjustment skills of people who are blind or visually impaired. The counselor should know the pathology of the loss of vision (if it was congenital, adventitious, or traumatic), and precisely how much vision remains. Each situation will affect the treatment plan differently.

It is important to know how well a person who is blind can maintain independence. Some considerations are

- What travel aid is used?
- What communications modality is used?
- How does the person maintain clothing organization?
- What are the person's skills in food preparation and hygiene?

The counselor must ask direct questions because the person who is blind may be ashamed of his lack of skills and unknowingly lie. For example, do not assume because someone has a white cane that it is used properly. Programs can consult with a local disability service provider who has experience working with people who are blind to find out what are good and/or acceptable levels of ability. Questions such as, "Tell me how often you've used Braille in the last 2 weeks," can then be used to assess each individual's level of ability. If the person who is blind has limited knowledge and skills about blindness, the counselor may need to arrange some form of training. This lack of knowledge and skills could be a factor in the person's substance use.

When interviewing people who are deaf, treatment programs should contact an interpreter referral service in their area to ensure that sign language interpreter services will be available when needed. The interpreter should

be a neutral third party hired specifically to interpret for the counselor and the person who is deaf; a family member or friend of the client should not be used as an interpreter. Family and friends often cannot be neutral and unbiased, which is the interpreter's responsibility. Use only qualified interpreters as determined by either a chapter of the Registry of Interpreters for the Deaf or a state interpreter screening organization. Ideally, the interpreter will have had previous experience working in treatment settings or will have at least attended workshops related to addiction treatment settings. However, it is not always possible to obtain an interpreter with this specialized training. In any case, prior to the session, the staff should try to meet with the interpreter to clarify the purpose of the interview and the meaning of the terminology and the questions to be asked.

Intake providers and counselors at any stage of the treatment process should realize that sign language interpreters have varying skill levels. If an interpreter has difficulty interpreting for a particular individual, the counselor should ask questions to determine if the problem lies with the skill level of the interpreter or the cognitive processing or language style of the client who is deaf. This is a critical piece of information for the counselor to have during the intake process so that the counselor does not misdiagnose the client or assign a level of functioning to him that is not correct.

Some of the questions during the intake process may be difficult to interpret into sign language. For example, some assessments include questions to test orientation to reality and cognitive functioning. In order for the interpreter to interpret these questions correctly, she could give away the answers. In these instances, the interpreter will need to discuss the question with the counselor to determine how the question can best be asked to obtain the information needed. Much of the language used in substance use disorder treatment will not be familiar to clients who are deaf and will need to be explained.

Additionally, some individuals who are deaf or hard of hearing may have limited communication skills. They may not have even been exposed to any formal system of sign language. In these cases, an interpreter may not know how to communicate questions to the person who is deaf. The screener can try to use props or pictures to help make the message understood in a different way. It may also help to hire a deaf interpreter to work along with the hearing interpreter. The deaf interpreter would be a native sign language user and thus is likely to have a better understanding of how to communicate with a deaf person who has minimal communication skills. If these methods do not work, it may not be possible to make the screener's questions understood by the client.

Intake interview with people with physical disabilities

When conducting an interview with an individual with a physical disability, make certain that table surfaces are the correct height, and in particular that wheelchairs can fit beneath them. Interviewers should try to place themselves so that they are no higher than the person being interviewed. They should be aware of the pace of the interview, and attempt to gauge when clients are becoming fatigued. In addition, some forms of chronic pain make lengthy interviews excruciating. Periodically inquire how the individual is doing and offer to take breaks in order to make the experience more tolerable.

It is important to consider whether an individual's physical disability may influence his responses in ways which portray him inappropriately. A person with a long-term back injury may, in fact, wish to return to work, but still respond that he doesn't "intend on working in the future." He may neglect to inform the interviewer that working even part-

time in the future may jeopardize his disability benefits, including medical services.

Adapting Substance Use Disorder Screening for Persons With Coexisting Disabilities

As stated above, the more information a provider has about a client's disabilities and functional limitations, the more she can tailor treatment to the client. As with any person with a substance use disorder, details about the patterns of abuse and dependence are also critical to effective treatment. This section presents modifications to screening and assessment questions for people with coexisting disabilities.

Drug and Alcohol History

It is important to understand the relation of drug use to an acquired disability. Some people begin using substances in response to an acquired disability; for others their substance use may have caused or contributed to the coexisting disability. Some people may not even be aware that their disability is substance-related. The use of prescription medication in combination with alcohol and the use of other people's prescription medications, are common for some persons with physical disabilities (Moore and Polsgrove, 1991). Consequently, make certain that this aspect of the drug history is well discussed.

Screening people with cognitive disabilities

Rather than asking generally about "abstinence," take a history of use. Ask, "Did you get high today?" or "What about yesterday?" Try to ask concrete questions, perhaps using time markers such as the 4th of July. It may be helpful to ask the person to relate his whole life story; opportunities to ask about substance use will occur during the telling of the story.

A client's understanding of "alcohol" may be different than the interviewer's. Be as specific as possible with clients—rather than asking if they "use alcohol," ask if they like to drink beer, wine, wine coolers, etc. Remember that wine coolers may not be the same as wine to many people. It may help to use props such as different glass or bottle sizes rather than asking how many ounces were consumed.

Do not assume people with cognitive disabilities understand the terminology being used; explain or define it and ask them to repeat back their understanding of the words. Instead of asking if they have had a blackout, describe a situation that would explain what this means. For example, ask, "Have you ever gone to a party and drank and the next thing you know you wake up and can't remember anything from the night before?" (It may also be necessary to ask if this problem ever occurred when the person was sober, or is still happening now, in order to check for dissociated symptoms.)

Psychosocial History

This history should look at an individual's work record, residential life, educational background, family, employment status, mental health history, and history of past abuse (since many people with disabilities have been victims of physical, emotional, and/or sexual abuse). It is also important that the assessment of a person with a disability gather information about involvement in vocational, physical, or social rehabilitation. The history should determine whether a person has had skills training, where she received it, and how long ago it was completed. The interviewer should determine when the training took place relative to the history of the substance use disorder. If the client was undergoing personal adjustment training and using substances at the same time, it is reasonable to assume that he will need to

repeat at least some elements of the adjustment training.

Use of Screening Information

Treatment providers should not feel the need to be experts on all disabilities or disability issues. Instead, providers should view the task of screening for disability symptoms as a benefit for individualizing and developing appropriate treatment goals. Treatment should be more beneficial to clients if their limitations are considered in the development of their treatment goals. This in turn should make the counselor's job less frustrating and difficult. Chapter 3 of this TIP discusses how screening information can be applied in treatment planning and counseling and the alterations that will need to be made for clients with coexisting disabilities.

3 Treatment Planning and Service Delivery

Considering the prevalence of people with physical, cognitive, and sensory disabilities who require substance use disorder treatment, treatment providers should be better informed about the particular needs of this segment of the treatment population. They should also put that knowledge into practice, which may require changes to the treatment program. Successful treatment for all clients must involve all levels of the treatment staff; changes at the systemic level will be reflected at the organizational level and, most importantly, at the client-counselor level where recovery begins. When such systemic and organizational change does not occur, treatment personnel do not receive adequate support, and they and their clients feel isolated—repeating and maintaining the feelings of isolation that are often at the core of addiction.

In order to make treatment as effective as possible, persons with coexisting disabilities will require specific accommodations. Treatment plans should be revised to accommodate the needs of people with coexisting disabilities, with recognition that not all clients respond equally well to the same types of treatment. If at all possible, treatment plans should be drawn up on a case-by-case basis; doing so will ensure better outcomes for all clients, not just those with disabilities. Understanding how an individual feels about her own disabilities will also enhance treatment.

Understanding Client Attitudes in Treatment

Denial

Kubler-Ross identifies five stages in the grieving process: denial, anger, bargaining, depression, and acceptance (Kubler-Ross, 1969). Denial of a substance use disorder is a common client characteristic that must be addressed by treatment professionals. But as they face multiple losses (a loss of physical or cognitive functioning and the loss of a substance upon which they are dependent), some people with coexisting disabilities may experience two types of denial at once: denial of the substance use disorder and of the disability. The presence of a coexisting disability can alter how a person manifests denial of his substance use disorder or can cause his denial to be focused solely on the disability. For a person with a disability, substance use may also be a form of "bargaining." She may think of her substance use as something she is "allowed" to compensate for a disability she must face. Recognizing her problem forces her to cope with all the often painful emotions typically experienced by any person in recovery, in addition to those related to her disability. For most people with severe disabilities, adjustment to this condition is considered a lifelong process (De Loach and Greer, 1981).

Most substance use disorder treatment professionals already have extensive knowledge of the complex ways in which psychological denial and addiction are intertwined, and they have developed methods of working with clients whose denial presents a significant obstacle to treatment. However, for people with disabilities, denial has additional dimensions. Some individuals may have used denial of their disability at various times in their lives as a legitimate coping mechanism to deal with the trauma of an accident or to push themselves toward a goal. Others will want to avoid the stigma and devaluation of being labeled. Other individuals may be cognitively unable to recognize their functional limitations, a problem that may only appear to be denial (see Figure 3-1 for some of the factors that influence a person's understanding of a coexisting disability). An addictions counselor may not have the time or the expertise to keep confronting the denial of the disability; he should make a referral to a peer counselor at a Center for Independent Living (CIL), whose job it is to help disabled individuals come to terms with the limits of their disability. The two counselors can then work as a team.

Risk Avoidance and Risk Taking

Another important issue in treatment planning is the extent to which risk taking and risk avoidance may shape the daily life of a person with a disability. Some individuals with disabilities have been taught or have otherwise come to believe that they should avoid sources of risk (e.g., risk of embarrassment, risk of rejection, risk of failure). Avoidance may become such a favored strategy that it takes on the force of a personality trait, resulting in increased isolation. For example, a person who uses a wheelchair may miss seeing a much-anticipated movie to avoid a situation in which she arrives at a theater and is unable to get in because of a physical barrier. A person with a

Figure 3-1
People's Understanding and Acceptance of a Coexisting Disability

People vary in how well they understand or accept their own disabilities. Some persons entering treatment for substance use disorders know what interventions their disabilities require. Others do not. Some people appreciate and benefit from accommodations to their disability, whereas others may be reluctant to acknowledge that some condition limits their functional capacity. The following are some of the factors that affect a person's willingness to accept the realities of her disability:

- The severity, duration, or specific functional limitations of the disability
- Societal reaction to and expectations of the person with a disability
- The developmental stage at time of the disability's onset
- Access to resources and societal mobility
- A history of risk-taking behaviors prior to the onset of the disability
- A history of having used substances to cope with a disability
- Recurring and episodic forms of personal grieving due to disability issues
- The amount of independence resulting from a person's lifestyle and personality
- Age (generally, younger people are more willing to eventually accept their disability)
- Marital status (married people are more willing to accept disability than single or unattached)
- Income (the greater someone's income, the more willing he is to accept disability)

Source: Chart modified from Li and Moore, 1998

visual or speech impairment may avoid riding the subway for fear of missing his stop or of having to ask for directions. A person with mental retardation may have been victimized by new "friends" so often that she avoids pursuing friendships. Long-term use of substances may be deeply intertwined with such avoidance strategies. Treatment planning can introduce situations, such as attending a 12-Step meeting or trusting an unknown group member, to which the person's first response may be impulsive anger, or exhibiting avoidance. Early in the treatment planning process, discussions of how a person with a disability uses avoidance strategies in daily life will be beneficial to both him and the treatment provider. The person with a disability should be encouraged and supported to try other strategies.

While some people with disabilities avoid social interactions or situations that involve risks, others take too much risk rather than too little. A client with a coexisting disability, especially if the disability is of traumatic origin such as traumatic brain or spinal cord injury, may be more likely to engage in high-risk behavior for two reasons. First, individuals who sustain injury-related disabilities are often prone to risk taking because of personality and behavioral characteristics, the same characteristics that contributed to their injury. Second, neurological damage can impair judgment and further increase risk taking. People with learning disabilities, especially those with attention deficit/hyperactivity disorder (AD/HD), may also tend to take excessive risks because they too lack sufficient skills or judgment to recognize and avoid risky situations. Obviously, continued risk-taking behavior often places the person in situations where sobriety is challenged.

Strengths-Based Approach

For treatment to succeed, all clients must understand the particular strengths that they can bring to the recovery process. A strengths-based approach to treatment is especially important for people with disabilities, who may, because they have so frequently been viewed in terms of what they cannot or should not attempt, have learned to define themselves in terms of their limitations and inabilities. Well-intentioned family members and friends may encourage dependence and may even feel threatened when the person with a disability attempts to achieve a measure of independence.

However, people with disabilities must also understand their functional limitations, especially in relation to their risk for relapse. One of the overriding goals of treatment for people with disabilities is that they gain and maintain self-awareness about their functional limitations and capacities, as well as their substance use disorders. A better understanding of one's unique learning needs is an important step toward sobriety. For example, some persons with cognitive disabilities experience a great deal of difficulty learning from written material. This can be a particularly difficult limitation to acknowledge, especially in group settings or a workplace. The client who learns that it is a sign of personal strength to make adjustments and seek accommodation for reading difficulties is not only more empowered to make important decisions relative to sobriety, but also understands the importance, for example, of expanding the repertoire of skills used to compensate for a low reading level.

It is key to the treatment planning process for the treatment provider to learn how well a person understands her disability. Some people will have a clear knowledge of the ways in which they are functionally limited, whereas others may deny having any limitations. Similarly, in the area of individual strengths, some people will have received extensive support from family, friends, and professional caregivers to pursue their interests and develop

unique talents, but others may have been overly sheltered or may have experienced repeated failures. A treatment provider should confer with a disability expert on this delicate topic of how to discuss a client's disability with him.

Treatment Planning

Treatment plans for people with coexisting disabilities should be flexible enough to take into account changes that may occur in a person's condition or new knowledge that may be gained during treatment. By law, providers will need to make accommodations for people with disabilities so that they will have equal access to all components of the treatment program. Many of these accommodations are simple to make and inexpensive, but all will require planning and understanding on the part of providers.

Making Treatment Accommodations

Many substance use disorder treatment providers have addressed the problems faced by individuals with coexisting disabilities, including those who are human immunodeficiency virus (HIV) positive or have acquired immunodeficiency syndrome (AIDS) and individuals with coexisting psychiatric disorders or disabilities from past traumas. However, the treatment field has been slower to address the needs of individuals who have physical and cognitive disabilities. These populations, especially since the advent of the Americans With Disabilities Act (ADA), present a new challenge to the field. Providers may be uncomfortable when first confronted with a person with a physical or cognitive disability. That unease can lead them to err in one of two directions, either by enabling the person to use his disability to avoid treatment or, conversely, by refusing to recognize that a legitimate need for accommodation exists.

The need for understanding

Some people with disabilities present in the treatment setting with issues that require a great deal of therapeutic understanding. Many of these clients begin treatment expecting that their needs will not be understood, and their previous experience has likely reinforced this view. This may lead a client to believe that no one understands her, and that she is therefore entitled to use mood-altering drugs in order to cope with her own situation (Moore, 1991c). In such cases, staff members who demonstrate an understanding of the disability, such as knowing about its onset and course, can show empathy while maintaining realistic expectations for the client's full participation in the treatment program (De Loach and Greer, 1981).

Providers should know the degree to which a disability affects a person's life. For some persons with severe physical limitations, resulting from conditions as diverse as cerebral palsy and spinal cord injury, the task of simply preparing for the day can be exhausting. Some people with disabilities must arise before dawn every day in order to begin the arduous process of dressing, conducting a hygiene program, and meeting transportation that may take hours to take them into town. Obviously in cases like this, treatment staff must consider pacing of assessments and treatment. Rest periods, breaks, and "downtime" become critical components of a successful rehabilitation program.

Reasonable treatment accommodations

If a client believes that he needs an accommodation, the treatment provider will still need to determine if the request is legitimate or an attempt to manipulate the treatment program. Most substance use disorder treatment providers are aware of client efforts to elicit enabling behavior from them. However, providers' vigilance in avoiding enabling may

predispose some of them to reject legitimate requests for accommodation. If there is any doubt on the part of the provider regarding the legitimacy of the person's request, he should consult a "disability expert" in order to make this determination (see Figure 3-2 on how to locate an appropriate expert). Of course, experts in disability services will themselves face uncertainty when trying to determine if an appropriate accommodation is being made or if it is enabling the client to avoid change.

Too much of the wrong type of modification, on the other hand, may unwittingly enable the person to avoid change. For example, whether she recognizes it or not, the provider may react by thinking, "He has it so hard, maybe he should be able to take it easy instead of reading all this material." Or even, perhaps in the case of a person with AIDS or spinal cord injury, "If I were in her shoes, I'd want to drink, too." Such misplaced sympathy is harmful.

Accommodation does not mean giving special preferences—it does mean reducing barriers to equal participation in the program. People with coexisting disabilities are harmed by a provider's complicity in their avoidance of all challenges to chemical dependency.

Figure 3-3 illustrates enabling, denial, and appropriate accommodation in the treatment setting. Making the distinction among denial, enabling, and accommodation is more difficult for persons with coexisting disabilities. Adding to the challenge is the fact that people may not always be able to articulate their disability-related needs. It is important for multidisciplinary teams of providers to discuss and resolve these issues on a case-by-case basis. Increased communication between the substance use disorder treatment and disability services fields will help providers understand the approaches and philosophies needed to treat people with coexisting disabilities. The Panel recommends cross-training between substance use disorder treatment providers and agencies that work with people with disabilities, including vocational rehabilitation (VR),

Figure 3-2
Locating Expert Assistance

"Experts" in disability services can be located several ways, depending on the nature of the client's disability and the local resources available. Clients who understand their disability may in fact be the best "experts" on their condition and specific needs; however, it is not uncommon that persons requiring treatment for substance use disorders will not understand basic aspects of their situation or condition. In such cases, immediate family members or close friends may be important sources of information and guidance. The treatment team should also consider contacting other sources: a disability specific service organization (e.g., United Cerebral Palsy, an organization for the blind or deaf, Association for Retarded Citizens), social workers, case managers, rehabilitation specialists, psychologists, nurses, or physicians associated with a social service agency providing disability services for the individual client in question (e.g., vocational rehabilitation, family services for people who are deaf and hard of hearing, the Department of Veterans' Affairs' physical rehabilitation unit, community case management services), or other organizations recognized by the disability community (e.g., CILs, governors' committees for persons with disabilities, Paralyzed Veterans Association, local or State consumer coalitions for persons with disabilities). More information on these and other pertinent organizations can be found in Appendix B; more on developing linkages with other agencies can be found in Chapter 4.

Figure 3-3
Responses in a Treatment Setting

1. **An agency has this rule: All clients must attend an Alcoholics Anonymous (AA) meeting every night.** A young person with TBI protests that he does not want to attend AA meetings because the meetings are filled with old people who don't understand him and don't think he should be taking medication for pain.
   Denial response: There are no exceptions to the rule. Everybody must attend AA every night.
   Enabling response: It's OK, you don't have to go if they don't understand your problem.
   Accommodation: We'll help you find support at the existing meeting, or a different meeting or support group that can better recognize and accept your legitimate medication needs.
2. A treatment program has three discussion groups during daytime hours. A person with multiple sclerosis asks to be excused from the third discussion group because of fatigue.
   Denial response: I'm sorry you're tired, but everyone has to attend all three meetings.
   Enabling response: If it's a problem, you don't have to go.
   Accommodation: Why don't you take a rest period in late afternoon, and attend a third meeting, or alternative treatment activity, in the evening?
3. A person with a visual disability is being coached by the treatment program in her job search. All the positions she finds either have schedules that require her to miss her AA meetings, or are in locations inaccessible by the public transportation she requires. She argues that she should not have to attend AA.
   Denial response: You're just making excuses. Figure out how to make it work.
   Enabling response: You're right. This is too much of a problem. Give up the AA meetings, or the work.
   Accommodation: We'll help you arrange to ride to work with a coworker, so that you have transportation to and from your job. Or else, we'll help you find work with a flexible schedule.
4. An unemployed person who is alcoholic with time on his hands and little social support is turned away from a State-run VR program because he has not yet maintained sobriety for 6 months. He is outraged but decides there is nothing he can do.
   Denial response: You'll just have to figure it out and get a job on your own.
   Enabling response: This is a terrible situation, but I guess you'll have to wait until January.
   Accommodation: We'll work with you to plan a course of prevocational activities that you can begin doing now. Then you can file an appeal with the State concerning the denial of services; we'll help negotiate with the vocational rehabilitation program for flexibility. (The program should work to get the system to admit persons who are compliant with treatment recommendations, even if they have not yet met the requirement in terms of months of sobriety. In this way the client can begin getting involved in productive activities. Agreeing with the client that nothing can be done encourages his sense of victimization.)

medical, and other professional specialists on specific disabilities, disability service providers, CILs, and disability education and advocacy organizations.

When treatment teams make the effort to accommodate individuals with coexisting disabilities, the quality of care improves for all clients. All clients can get more out of treatment

Figure 3-3 (continued)

5. **A client with an alcohol use disorder who is deaf and lives in a remote rural area has few social** contacts, and these are all at the local bowling alley, where her acquaintances tend to drink alcohol.
Denial response: You're an alcoholic—you just have to stay away from bars.
Enabling response: You need to get out and socialize. Go, but try not to drink.
Accommodation: It's possible for you to see your friends at the bowling alley and not drink alcohol, even if they are. We'll teach you the skills to socialize in that setting without drinking alcohol, and teach you to recognize cues that indicate you are vulnerable to relapse. (By making such an accommodation the treatment program recognizes the unique challenges this person faces in attempting to build sources of social support, as well as the additional responsibility of the program to teach the skills she will need to function in the settings she is able to identify. If the program insists that a person avoid all settings where alcohol is served it has a responsibility to help the person find other sources of social support and companionship. Simply telling her to "stay away from bars" denies that isolation is also a threat to her sobriety.)

that is individualized and that takes their specific functional capacities and limitations into account.

Extending treatment times

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals has found that individuals who are deaf and hard of hearing have less access to prevention and intervention programs and less knowledge about addiction and recovery than nondeaf clients who enter treatment. Therefore longer term treatment may be required for them to have a level of knowledge similar to nondeaf clients when they leave treatment (Guthmann et al., 1994).

People who are blind and those with a cognitive disability have similar problems with which to contend. Sighted people gather approximately 80 percent of their information through their vision. Obviously, people who are blind or visually impaired cannot take in as much information through reading or through conversation. Many cognitive disabilities also affect the rate at which people can learn, and so people with these disabilities may also require more treatment time to understand the same amount of information.

Motivational Aspects of Treatment

Counselors should work with all clients to decide what incentives will best motivate them. Motivational strategies in treatment involve a number of approaches, including assisting the client to better understand the intrinsic rewards of a sober lifestyle and the negative consequences of continued use. For people with coexisting disabilities, these rewards and consequences can sometimes be different from those of other individuals.

Considerations for people with physical disabilities

For a person with a spinal cord injury, there are a number of medical concerns associated with the disability that are dramatically exacerbated by substance use. Chronic bladder infections are relatively common for persons with spinal paralysis and other mobility impairments. Alcohol consumption promotes, irritates, and inflames bladder infections, as well as nullifies the effects of antibiotics. Alcohol consumption has been identified as contributing to *autonomic hyperreflexia*, a nervous system reaction that leads to a rapid and sometimes fatal rise in blood pressure. Some persons with mobility impairments experience difficulties with

balance—even small amounts of alcohol or mood-altering drugs can impair balance to the point that falls and other problems are more likely to occur. A fall for a person with a mobility impairment can be more costly and medically debilitating than for someone without such a condition. Anecdotal evidence from physical rehabilitation programs indicates that persons with spinal cord injuries who consume substances to the point of intoxication often experience decubitous ulcers of the skin (pressure sores), a serious medical condition that can take months to heal. Persons with physical impairments are also more likely to be using prescription medication for medical management of their disability. Alcohol and drugs nullify the effects of some drugs while making others potentially lethal. Liver inflammation also occurs more rapidly when alcohol use is potentiated by some prescription drugs.

Considerations for people with cognitive disabilities

People with cognitive disabilities may have difficulty recognizing the negative consequences of their substance use, which does not necessarily mean they are in denial of their problem. Showing some people with mental retardation how substance use affects other aspects of their lives will provide them with strong motivation for continued sobriety (see Figure 3-4).

Alcoholics who have sustained TBI often perceive alcohol as improving their social interaction and comfort level, when it is actually reducing social judgment and insight to an even greater degree than it does with other, nondisabled drinkers. Clients with TBI are at a much higher risk for seizures, in general, and they should be made intensely aware of alcohol's effect in further lowering their seizure threshold. TBI patients are also at least twice as likely as other individuals to sustain additional

Figure 3-4
Development and Coordination of Goals

Fred has mental retardation and is living in a group home and working with housing program staff so that he may move with a roommate into one of the program's apartments in 2 years. Short-term goals developed with housing staff may include refining meal preparation skills, adhering to a schedule for cleaning the house, and developing interpersonal skills to solve differences with housemates. Simultaneously, he will be working daily in a transitional employment program with the goal of graduating to competitive employment in a couple of years. Short-term goals developed with job counselors may include learning proper grooming and punctuality. Fred may seem to be advancing with little trouble toward the ultimate goals of housing and vocational independence only to experience repeated and discouraging setbacks due to monthly episodes of binge drinking. The counselor should help him understand the concrete cause-and-effect relationship between staying sober and achieving greater independence, which may not be clear to him. Treatment goals to reinforce this direct association should be developed. Treatment plans should identify specific behavioral goals and a number of different reinforcers for making progress (e.g., tokens toward the purchase of his own "Big Book"; homework of reporting his daily activities and successes to a case manager, counselor, 12-Step sponsor, or family member; a "sobriety chart" on the counselor's wall where he can see his progress charted).

brain injuries, a risk that rises with alcohol use (Corrigan, 1995). Educating the client about these problems can increase his motivation for abstinence (Langley et al., 1990).

Consequences

Developing a treatment plan often requires contracting with the individual to identify specific behaviors that indicate that the plan is not working and to determine what consequences will occur when these behaviors become evident. In case problems do arise, a graduated series of appropriate consequences will enable a better response on the part of treatment staff. A program may require outside consultation from a disability expert (see Figure 3-2) to develop an understanding of what consequences are appropriate, and should try to have such an expert as part of the treatment team. An example of how one program, the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, works with behavioral contracts for people who are deaf is presented in Figure 3-5.

Contracts with people with disabilities may need to be more explicit than those with other people, and the consequences for relapses in particular may need to be individually tailored to what the individual is realistically capable of achieving. Discharging a patient from the treatment program for a single relapse, for example, may be counterproductive for many people with coexisting disabilities, especially considering how difficult all life transitions can be and how limited the options may be for alternative treatment or care. It is possible that dismissing a client with a coexisting disability

Figure 3-5
Behavioral Contracts in a Treatment Program for People Who Are Deaf

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals uses a behavioral approach with clients that includes education and support designed to help individuals identify and correct self-defeating behaviors. Intervention efforts are matched to behaviors of concern. An initial intervention would typically be a private discussion with the counselor, which often helps the client recognize and change the behavior. If the behavior continues or becomes worse, a behavior contract might be an appropriate second-level intervention.

Behavior contracts may be utilized for incidents such as the violation of unit rules, arguing about staff directives, failure to complete work on time, failure to focus on treatment, or focusing on the needs or issues of other patients (rather than one's own). Behavior contracts specify the behaviors for which they are given as well as the changes that are expected.

Another behavior management technique used is the probation contract. Probation contracts may be used to help a client recognize behaviors that seriously threaten the success or quality of her treatment experience. It is used as a followup to a behavior contract if a client does not respond positively or is openly defiant to the terms of a behavior contract. Probation contracts also specify expected changes in the client's behavior and may include an assignment that helps the client identify and change her behavior. Failure to adhere to the probation contract may result in the client being asked to leave the program.

for a relapse will shut the door to treatment for some time.

Some nondisabled people in treatment may protest the "special treatment" of an individual with a disability, and the counselor should be prepared to address that issue with all clients in the program. The provider should emphasize that program policies, procedures, and practices aim to ensure accessibility and promote success for everyone, and therefore treatment plans need to be individualized. It is helpful to identify early on any needed exceptions to the routines of the treatment program for a person with a disability and to explain that accommodations for persons with disabilities simply give them the help they need to meet shared goals. The exceptions and the rationale for these exceptions should be discussed openly in group meetings so that peers are aware of the exceptions and why they need to be made. The group may participate in some problem solving and have other suggestions that may be helpful. These discussions will allow the person with a disability to work in partnership with his peers as opposed to being seen as the recipient of special favors. However, some people with disabilities may, rightfully, wish to preserve their privacy and not have their disabilities discussed, and clients should be consulted about their feelings before such open discussion proceeds.

As discussed below, when a person with a disability fails to attain a treatment goal, one consideration should be that the treatment accommodations were not sufficient and the treatment plan did not articulate the proper steps for that person to reach that goal. For example, if a nondisabled client fails to complete a written assignment of a Step 1 report for a 12-Step program, he may experience a consequence, such as withdrawal of a leisure activity. A client with a cognitive, sensory, or physical disability, however, might be unable to complete such a report. In this case, however, the program may respond by working with her to develop an accommodation. If the individual agrees to make an audio recording of the report and fails to do so, then consequences follow. Figure 3-6 presents three common treatment tasks with consequences and accommodations for people with disabilities.

Provide Accessible Leisure Activities

Treatment programs often try to encourage people to participate more in leisure activities. However, many treatment programs have difficulty identifying and responding to the needs of people with disabilities. The following sections offer suggestions for making recreation programs as inclusive as possible.

Leisure activities for people with physical disabilities

Many people with disabilities resign themselves to spectatorship because their disabilities often force them to sit on the sidelines. Participating in enjoyable activities with others and having fun without consuming substances is a learned skill that many persons with disabilities don't have an opportunity to practice. It is essential that all clients participate in planning leisure activities, and programs with rigid approaches that exclude clients from such participation should consider changing their policies.

A physical disability can contribute to potential medical problems, such as poor circulation or digestion, obesity, heart disease, or other medical conditions. The often sedentary lifestyle associated with substance use only makes these conditions more pronounced. Exercise and activity can stave off these problems; therefore it is especially important for counselors to find activities that people with disabilities can participate in.

Treatment staff may need help adapting leisure activities so that all people with disabilities can participate. The local Special

Figure 3-6
Sample Contracts for People With Disabilities

Task:	**The individual must write a history of her addiction during the first 3 days of an inpatient program.**
Consequence:	Failure to accomplish the task will result in a loss of program privileges (e.g., not viewing the Friday night movie, placing vocational goals or plans on hold, delaying graduation from treatment).
Accommodations:	■ Allow more time. ■ Allow the use of alternative formats (e.g., someone who is blind, deaf, or cognitively impaired can dictate or draw aspects of his history). ■ Be specific in assigning a time period for reporting substance use history (e.g., last year, "since my arrest").
Task:	The individual in outpatient treatment must attend all groups.
Consequence:	Missing a group will result in automatic discharge.
Accommodations:	■ Work with the individual to be sure a ride is available. (Transportation problems can be substantial for some persons with disabilities.) ■ Pair up a person with a coexisting disability with a nondisabled group member who will help ensure he gets to the group session. ■ Substitute another activity if the individual cannot get to the meeting (e.g., an individual session, a 12-Step meeting, writing a report). ■ For persons with memory problems, call and remind them that a session is occurring or assist them in creating memory books that include necessary information on group meetings.
Task:	The individual must attend 90 Alcoholics Anonymous (AA) meetings in 90 days.
Consequence:	Failure to attend will mean that the client is reported as noncompliant to referral sources.
Accommodations:	■ Pair up the individual with a nondisabled group member who can accompany her to a meeting. Take extra time to assist someone in finding a temporary AA sponsor who understands disability issues or is willing to learn. ■ Substitute another activity if the client cannot get to a meeting, such as requiring attendance at other groups or self-help meetings (e.g., disability-related groups in a rehabilitation program, Schizophrenics Anonymous, church groups). ■ Have the client report daily by phone to the counselor or AA sponsor.

Olympics Committee is one resource for youth and some adults with developmental disabilities, and can be located through local school systems. The National Association of Therapeutic Recreators assists adolescents and adults in accessing a whole range of activities from which they have traditionally been omitted; their offices can be located through university disability offices or local physical rehabilitation programs. YMCAs, YWCAs, Boys' Clubs, United Way, and CILs also can

assist treatment staff in identifying specialized recreational programs that may be of assistance.

Leisure activities for people with sensory disabilities

In the case of individuals who are deaf and prefer to socialize with other people who are deaf, leisure activities with a supportive peer group are difficult to find. The size of the Deaf Community is limited. In any State, however, there will be different clubs and organizations sponsoring activities for community members. Alcoholic beverages are present at many community events, and, if not, people may go to bars after the event. It will be difficult for a person who is deaf to find alcohol-free activities that include other people who are deaf. There may be limited options to form a peer group that is deaf and substance-free. Socializing with hearing peers who do not know sign language but who are sober may not be a realistic alternative, because the person who is deaf could feel extremely isolated. The counselor and client who is deaf need to be creative in developing plans for the client to become involved in leisure and social activities.

Adjust Treatment Goals To Fit the Person

For clients with disabilities, failure to achieve treatment goals may indicate that not enough attention has been paid in the treatment plan to outlining a series of discrete steps to meet the goals, or that the goals themselves need to be adjusted. In setting a goal, the client and the counselor must work closely to understand all the physical and cognitive requirements of meeting a goal. Sometimes it will be necessary to teach someone how to make a new friend before he can be expected to give up the only one he has in order to remain sober.

People with coexisting disabilities face many challenges, barriers, and apparent dead ends, and the skills training and decisionmaking practice necessary to address these issues are often not available in accessible and comprehensible ways. Consequently, treatment goals for these consumers need to be more individualized, expansive, and reflective of the immediate environmental challenges which confront them on a daily basis. Obviously, some of these ancillary, but essential, goals need to be accomplished with the assistance of persons beyond the immediate treatment team.

Adjustments for people with physical disabilities

The treatment plan for a person with a physical disability needs to take into consideration not only the physical limitations the person might have, but also the psychological and social consequences of the disability. Issues that need to be addressed may include impulsivity, social isolation, low self-awareness relative to medical or psychological needs, anger, feelings of hopelessness, or outright panic that life without substances will be unbearable considering the disability. These issues are hardly new to the treatment provider, nor are they unique to persons with disabilities; however, a disability may exaggerate the severity of these conditions or their impact on recovery.

The counselor should work with the client to set up incremental goals, rather than expecting major changes all at once. For example, a person who uses a wheelchair and her counselor may set a goal to attend an Alcoholics Anonymous (AA) meeting at a certain site several times a week. They may then set several interim steps for her to take with the ultimate goal of regular meeting attendance. These may include having her call the site to ensure its accessibility, working with the counselor to arrange reliable transportation, and making a trial run to the site during a less busy time of the day, perhaps with a friend or with the counselor. In the end, the goal may or may not be attained, and more discrete steps may be needed before it is achievable. For example, the transportation may prove to be unreliable on

some days, and alternative transportation may need to be arranged or a wheelchair-accessible AA meeting site located.

For another person with a disability, regularly preparing evening meals at home may be a treatment goal, especially if he has been accustomed to eating dinner at a bar. A number of small steps are then successfully negotiated: The person receives cooking skills training from another agency, basic cooking equipment is obtained, and a grocery delivery service is engaged. However, he may then find that he tires easily after standing for even a short period in the kitchen. An energy conservation program may be a necessary additional step before he can fully use his new skills. A disability expert on the treatment team can help the individual create strategies to conserve energy, such as obtaining a high stool to sit on during meal preparation.

Adjustments for people with cognitive disabilities

A similar process of planning small steps to meet a goal should be undertaken for people who have cognitive disabilities. For example, a person with brain injury and alcoholism may set as a goal avoiding drinking on Friday night after picking up her Supplemental Security Income (SSI) check in the afternoon. If she does not drink then several other leisure activities are possible during the weekend, all of which she enjoys and benefits from. She and her counselor may then develop the interim goal of cashing the SSI check at a bank on Friday instead of the liquor store, and plan a structured, sober activity for immediately after the check cashing. The individual could also meet with her case manager for the purpose of budgeting and paying bills. She and the counselor or case manager can discuss how she would like to spend what is left, and if she would like to save for something special. Alternatively, the treatment program may wish to consider forming a relationship with a nearby supermarket to ease the way for its clients to cash checks there. The individual and counselor will then need to establish other steps toward the goal of not drinking on Saturday morning, perhaps through specific exercises in treatment that desensitize or eliminate the environmental cues that prompt her weekend bingeing.

Adjustments for people with sensory disabilities

When developing treatment goals, the counselor needs to consider what is realistic for the client who is blind or deaf. It is important for the counselor to know what resources are available in his area. For example, in all areas of the country except a few metropolitan areas, there are not enough interpreted 12-Step meetings available for a person who is deaf to attend meetings every day. Therefore, 90 meetings in 90 days is an impossible goal for the person who is deaf to achieve. Attending one meeting per week is a more realistic goal. Counselors who are not experienced in working with deaf clients should consult a professional who has that experience to provide guidance during the treatment planning process.

When working with clients who are blind or visually impaired, the counselor must be keenly aware of their blindness adjustment skill level and the availability of the proper adaptive equipment in the environment. Before giving a reading or writing assignment, the provider must make sure the required equipment is available. Additionally, if the blind person is asked to attend 12-Step meetings, transportation must be arranged. Figure 3-7 presents other suggestions of how to interact better with clients who are blind.

Revising and Documenting the Treatment Plan

Because the counselor's knowledge of an individual's strengths and limitations is always growing, no treatment plan should be static. In

Figure 3-7
Accommodating Clients Who Are Visually Impaired

Improving interactions with an individual with blindness or low vision

- Develop a positive attitude about blindness.
- To guide a person who is blind, let him take your arm. When encountering steps, curbs or other obstacles, identify them.
- When giving directions, be as clear and specific as possible including distance and obvious obstacles.
- Speak to the person in a normal tone and speed.
- It's okay to touch a blind person on the arm or shoulder to convey communication.
- Don't touch or play with a working guide dog.
- Ask the person how much vision she has and what communication modality she is most comfortable using.
- When leaving a room, say so.

Solutions to access problems

- Keep pathways clear and raise low-hanging signs or lights.
- Use large letter signs and add Braille labels to all signs.
- Keep doors closed or *wide* open; half open doors are hazardous.
- Have adaptive equipment available so people who are blind can be full program participants (i.e., talking computer, Brailler, etc.).
- Make oral announcements; don't depend on a bulletin board.
- Add raised or Braille lettering to elevator control buttons, and install entrance indicators at doorways.
- Utilize radio and the newsletters of organizations serving the blind for announcements and advertising.
- Make optical magnifiers and aids available for people with visual impairments.

Source: Substance Abuse Resources and Disability Issues, 1995.

the case of a person with a coexisting disability, there may be even more reason why revision is necessary and careful documentation is called for. An individual with a disability may need to explore several methods for learning something or fulfilling a goal before an achievable approach to the situation can be identified and implemented.

Frequent revision of the treatment plan is crucial, for instance, when working with clients with TBI because they often show a dramatic recovery curve over the first year to second year following their accidents. Additionally, periods of even relatively short detoxification can dramatically clear cognitive functioning. Given these realities, treatment plans need to be frequently updated to account for these clients' rapidly changing and improving memory, reasoning, and attention abilities. Therapeutic interventions that would not have been appropriate even a few months previous can rapidly become within the client's grasp. However, counselors must keep in mind that these cognitive abilities may improve at different rates. For example, certain language abilities may be recovered early, while memory deficits can continue to plague the client for years after the head trauma. The treatment plan must be flexible enough to accommodate these rapidly changing cognitive abilities.

Frequent consultations with clients

In evaluating and revising a treatment plan treatment providers should get cooperation from the client. Many programs already comply with licensing regulations to review and revise the treatment plan periodically (e.g., weekly or every 30 days). Aside from such formal evaluations, frequent consultations or "reality checks" are essential. All clients should be offered the opportunity to review and revise the goals and objectives of their treatment program on a regular basis. The provider needs to know whether there are barriers in the program or problems with the treatment approach. The provider should make every effort to ensure that such discussions are serious efforts. They should ask questions about specific goals, about how the individual is feeling, and about job or personal situations troubling him. Failure to perform continual evaluations may result in the individual abruptly leaving the program.

The counselor should take every opportunity to learn more about the client. For example, during a group outing, a counselor may take what she considers to be a short walk with a person and observe that he is rapidly tiring and lagging behind. Specific questions about his lack of stamina or level of pain may reveal a more extensive limitation than the counselor originally understood, which may lead to changes in the treatment plan. In conversation during this walk, the person with a disability may bring up other critical psychological issues related to his disability. The client may confide that he avoids the company of others when he is outdoors because many times in the past others have simply abandoned him when he lagged behind, and he has had to find his way back alone. The fear of abandonment and betrayal by friends—perhaps by the counselor and the treatment program—may be a significant issue preventing his deeper involvement in treatment. Discussing this issue, as well as problem solving with the client about how to keep up with others outdoors, (e.g., by use of a scooter), may be highly productive.

Careful documentation

To keep treatment on track, it is important that case notes reflect the client's progress or lack of progress toward treatment goals. Accurate, evaluative notes are one way for counselors to stay focused on a client's particular issues, and documentation of all efforts at accommodation is needed to verify ADA compliance. When people relapse, case notes often provide valuable information to explain the relapse. In addition, careful documentation is essential in negotiating with managed care firms to allow extra time for people with disabilities to meet treatment goals.

The treatment plan should document all alterations to the usual treatment procedures that are being made. Careful documentation also allows providers to see what goals have already been met and what procedures are working for the client. For example, a person with mental retardation may not be able to write or share a report on why she is powerless over drugs and alcohol (i.e., Step 1) and may demonstrate little understanding of basic treatment concepts, yet be able to maintain abstinence. In discussions with the person, the counselor may come to understand that her abstinence is mostly attributable to the AA group, which she enjoys attending nightly. If a person who is blind does not complete a reading assignment, this should be documented and investigated. If the assignment was not completed because the facility does not have the proper material and equipment it should also be noted that (1) the patient is not held responsible and (2) he is not fully benefiting from the program.

If an approach does not work, the outcome should still be carefully documented to prevent duplication of effort by other programs in the future. By the same token, details of what is

successful for a person should be documented, particularly for persons with cognitive disabilities who may not be able to tell future caregivers which treatments have been effective and why. Careful documentation allows all treatment providers to see the goals of treatment and the accommodations that have been made to meet them.

Counseling Issues

The Counseling Environment

Making accommodations for counseling begins with a consideration of the physical environment where counseling will take place. People with different disabilities may encounter different obstacles to treatment in their environment. It is best to make accommodations on a case-by-case basis, but some disability-specific factors to consider include the following.

Modifications for people with physical disabilities

The arrangement of furniture can be important—the room should be accessible for all clients, and those who require an assistive device, such as a wheelchair, should have room to maneuver. Counseling rooms should also be near living areas and bathrooms and should be easy to find. Some table tops and desk surfaces should be high enough in the air to be accessible to people in wheelchairs. (Some programs accommodate to these occasional needs by storing wooden blocks that can be placed under tables to elevate them to the proper height.)

Providers of chemical dependency services need to keep in mind that the most important element to ensure physical accessibility for a facility may be the attitude of staff. If they are open and accepting—and willing to be flexible—most physical accommodation issues can be addressed successfully.

Modifications for people with sensory disabilities

Counselors should take into account room arrangement and lighting. It is not readily apparent, but lighting can be very important when there is a person who is deaf in a mainstreamed program. Lighting needs to be sufficient for the person who is deaf to see the interpreter, especially during a movie or video when the lights might be lowered. Blinds or curtains may need to be closed in order to reduce or eliminate glare and enable the person who is deaf to effectively see the interpreter and understand what she is signing. Persons with a visual impairment may also be bothered by the glare from windows and fluorescent lights. The counselor should ask if the client is comfortable with the lighting.

Modifications for people with cognitive disabilities

The presence of visual distracters, such as photos, artwork, and desktop toys, may make it more difficult for someone with AD/HD to concentrate. The glare from windows and fluorescent lights can also be a distraction for people with AD/HD, and the amount of noise should be kept to a minimum. A treatment room away from noisy areas can help such clients gain the focus they need.

Individual Counseling

There are many accommodations that programs can make to modify individual counseling for people with coexisting disabilities, a number of which cost little or no extra time and money. Counselors must be willing and able to work with all people with disabilities. They should be aware of their own issues concerning disabilities and be able to discuss with other program staff potential issues that may incline them to be especially positive or negative regarding a person with a disability. See the section on staff training in Chapter 5 for more information on

how counselors can work through their own feelings about disabilities.

When working with people with coexisting disabilities, some adaptations to counseling may be necessary depending on each individual's capacities and limitations. Some modifications, however, may be helpful for all people with disabilities. For instance, session times should be flexible, so that sessions can be shortened, lengthened, or occur more frequently, depending on the individual treatment plan. For all people with disabilities, the transmission of unconditional positive regard will help the client achieve sobriety as much as anything.

It may be useful to talk about disability issues in individual counseling, especially if the person does not want to talk about them in a group setting. Sometimes an individual's disability and societal attitudes toward it play a large role in substance use. However, there are times when the topic should be avoided.

In addition to structured individual counseling sessions, other opportunities for one-on-one counseling may present themselves during the course of treatment. There is often an opportunity for individual counseling at the end of a group session. The counselor and person in treatment can take 10 minutes together to review what went on in group. More frequent, less formal contacts may benefit the individual as well. Drop-in policies encourage people to stop by and say hello. The opportunity to drop in and announce that they "stayed clean today" helps motivate many people in treatment, as do telephone check-ins.

Sometimes counseling for a client with a disability will not require more time in therapy, but rather more preparation time prior to the actual counseling session. This preparation may include a trip to the library to research a disability, or involve a conversation with an expert.

Modifying counseling for people with physical disabilities

Counselors are trained to observe personal physical boundaries, but the sense of what is proper may need to be modified for some people with disabilities, as counselors may have to assist with adjusting a wheelchair, etc. When the proper course of assistance is not apparent, ask the client for guidance. The relative height of the counselor and the client, when seated and talking, may also be an important consideration when working with someone who has a physical disability. Disproportionately great differences in seated height can hinder communication, especially relative to body language.

If a person with a disability has limited transportation options, conduct individual counseling by telephone, go to the person's house, or meet at a rehabilitation center or other alternative site. Home visits can offer valuable insights into a person's life and ultimately facilitate effective delivery of treatment. The Consensus Panel recommends that providers make home visits if necessary, which may be reimbursable under case management services. Going to the residence of an individual with a disability also provides invaluable information about a client's lifestyle, interests, and immediate environmental challenges.

Modifying counseling for people with cognitive disabilities

Some individuals who have sustained a TBI or have cognitive deficits secondary to a substance use disorder have decreased abstract reasoning abilities and reduced ability to solve problems. However, these areas of deficit may not be apparent because a person can retain his language abilities. Therefore it is important to ask people with TBI to provide specific examples of a general principle; for example, a

client can be asked to identify three specific ways drinking or using drugs gets him "in trouble." His responses can be written on a note card to help remind him of the consequences of his drinking. In this way, both the abstract reasoning and memory problems that are common in TBI can be addressed. A number of other suggestions for working with people with TBI are outlined in Figure 3-8.

When working with people with cognitive disabilities, counselors need to know that insight and behavior may not be closely correlated. For example, a person with a cognitive impairment may actually reduce substance use over time even though her responses suggest that she is not yet ready to do so. Likewise, there are persons who can hear information and repeat it back in a counselor's office, but cannot maintain the behavior elsewhere. Counselors must consider both people's insight and their behavior.

Counseling materials should be organized in advance, and the goals of counseling stated clearly up front and repeated often. Memory books can help people with cognitive disabilities keep track of essential information such as names, meeting times, and maps of local areas. The main points of the treatment session can also be chronicled and dated. The counselor should make sure people use these aids. They should watch a client write down his next appointment in his pocket calendar, and, on the telephone, ask him, "Are you writing this on your calendar now?" The conversation should not be ended until the counselor is sure the client has done so.

Most people who are cognitively disabled have trouble transferring knowledge from one situation to another. Thus the consequences of drinking must be gone over and over incident by incident. Counselors can teach clients with TBI and AD/HD, and others with poor impulse control, to hesitate and "think a drink through" before acting. People with severe cognitive impairment may need help developing a repertoire of internal controls, rather than simply responding to external control.

Discussions should be kept concrete. People with mental retardation may not understand abstract concepts such as "powerlessness," "depression," "avoidance," "unmanageability," and "sanity." They may even have trouble with more basic terminology like "sobriety," "abstinence," "relapse," or even "drunk." Regularly review the terminology of the treatment program and any other programs (such as AA) in which the person might be participating. Do not assume people with cognitive disabilities understand the terminology used. The counselor can ask the client to repeat back her understanding of these terms. Use short sentences, and skip elaborate, abstract analogies. Goals should also be phrased in concrete terms.

When working with clients with limited language skills, try using alternative media to communicate ideas. If, for example, the client cannot read and also has short-term memory deficits or auditory processing problems, then a tape recorder will not solve the reading problem. Some people who are nonreaders will do far better with a video (looking and hearing at the same time) than with an audiocassette. Some people will learn better by drawing or making a collage of a concept. For example, a client who has difficulty explaining her understanding of her 12-Step group's first step may find it easier to draw five pictures showing how her life is unmanageable. Individual counseling sessions are an ideal time for the counselor to review such materials as AA's *Big Book* that a person with a cognitive disability may not be able to read.

Counselors should not assume that insight into drinking behavior will also affect other drug use—for a person with a cognitive disability these behaviors may be very different.

Figure 3-8
Suggestions for Providers Working With Persons With Brain Injury

1. **Try to determine a person's unique learning style.**
   - Ask how her reading is, how well she writes, or evaluate via samples.
   - Both ask about and observe a person's attention span; be attuned to whether attention seems to change in busy versus quiet environments.
   - If someone is not able to speak (or speak easily), inquire as to alternate methods of expression (e.g., writing, gestures).
   - Evaluate whether someone is able to comprehend either written or spoken language (is there a receptive language problem?).
2. Help the individual compensate for a unique learning style.
   - Modify written material to make it concise and to the point.
   - Paraphrase concepts, use concrete examples, incorporate visual aids, or otherwise present an idea in more than one way.
   - Encourage the individual to take notes or at least write down key points for later review and recall.
   - If the treatment program includes a schedule, make sure a "pocket version" is kept for easy reference; homework assignments should be written down as well.
   - After group sessions, meet individually to review main points.
   - Provide assistance with homework or worksheets; allow the person more time and take into account reading or writing abilities.
   - Enlist family, friends, or other service providers to reinforce goals.
   - Do not take for granted that something learned in one situatio ı will be generalized to another.
   - Repeat, review, rehearse, repeat, review, rehearse.
3. Provide direct feedback regarding inappropriate behaviors.
   - Let a person know a behavior is inappropriate; do not assume he knows and is choosing to do so anyway.
   - Provide straightforward feedback about when and where behaviors are appropriate.
   - Redirect tangential or excessive speech, including a predetermined method of signals for use in groups.
4. Be cautious concluding that an underlying emotional state is the basis of an observed behavior.
   - Do not presume that noncompliance arises from lack of motivation or resistance; check it out.
   - Be aware that unawareness of deficits can arise as a result of specific damage to the brain and may not always be due to denial.
   - Confrontation shuts down thinking and elicits rigidity; roll with resistance.
   - Do not just discharge for noncompliance; follow up and find out why someone has not showed up or otherwise not followed through.

Source: The Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 1998.

For example, the person may agree not to drink anymore and may understand the consequences of drinking. The same person, however, may continue using marijuana and may not truly understand the dangers associated with that behavior.

Although counselors must not expect too much from people with cognitive disabilities, they should also not expect "too little." Many are just as capable as any other client of having the insights that are important in treatment, such as "when I drink and drug, I get in trouble." (Exceptions include clients with severe memory deficits and some with TBI.) Counselors will have greater success by going slowly and reiterating with each crisis the role that substance use played. Keep asking after each relapse: "What happened and what did you think would happen? How do you feel about what happened? How will you handle the situation differently next time?"

Modifying counseling for people with sensory disabilities

The counselor should ask the client who is deaf or hard of hearing what accommodations he needs. If the client is hard of hearing or deaf and does not use sign language, he may request only to have a counselor whom he can lip-read. For instance, he may not be able to lip-read a counselor with a beard and mustache, but a counselor with no facial hair blocking his mouth may be acceptable. The individual may need an interpreter, an assistive listening device for sound amplification, or Computer Assisted Realtime Transcription (CART). The accommodation requested should be provided.

Regardless of the mode of communication, the counselor should be seated so the deaf or hard of hearing client can look directly at her. When an interpreter is used, the interpreter should be seated next to the counselor in order for the client to see the counselor and the interpreter at the same time. The counselor should speak directly to the deaf client, using first person tense, as if the interpreter was not present. It is very common for hearing counselors (who have usually had little or no experience communicating with a person who is deaf and using an interpreter) to speak to the interpreter (saying "tell him…") rather than to the client. There may, however, be instances where the interpreter needs to ask the counselor or the person who is deaf for clarification of something the counselor has said, in order to interpret it appropriately. This sort of interruption is part of the interpretation process. However, the counselor should not try to include the interpreter in the counseling process except to facilitate communication with the client.

Many clinicians worry about confidentiality when using interpreters and fear that the use of interpreters will make it difficult to develop rapport with a client. Treatment programs should realize that sign language interpreters who belong to The Registry of Interpreters for the Deaf (RID), the professional association for sign language interpreters, follow a code of ethics that includes confidentiality of job-related information as one of its tenets. The staff of a treatment program can emphasize the importance of discretion in this situation by informing the interpreter of the strict laws regarding confidentiality in substance use disorder treatment.

Certain programs for the deaf have successfully used alternative media in place of the writing assignments often given to hearing clients. The Clinical Approaches manual developed by the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing contains numerous drawing assignments concerning concepts important for recovery that clients can be given as homework. These activities are particularly useful for clients who are deaf and may not be comfortable with their written English skills or for those with minimal communication skills in sign language.

Both one-to-one and group discussions are more tiring for people who are blind or visually impaired because they lack the benefit of observing facial expression, gestures, and posture. Sighted counselors can help their blind clients by avoiding visual images in conversation that a congenitally blind person will not understand. People who are blind will also require more time for reading assignments. A good print reader may read and comprehend from 600 to 700 words per minute (wpm), while a good Braille reader reads only 100 wpm. "Reading" an audiocassette proceeds at 200 to 250 wpm. These alternative ways of reading take not only more time but more energy as well.

Group Counseling

While accommodations may be needed to integrate people with coexisting disabilities into group counseling, it is important to first emphasize what all group members have in common. Counselors can emphasize to the group that, despite a wide variety of individual differences, all members are there for the same reason. Everyone is present because they cannot control their substance use, and they want to stay sober.

Some counseling groups with a single person who has a visible disability may meet on a regular basis, and disability issues are never discussed. For other groups, this topic may emerge quickly. Although it's not possible to state one policy that applies to all situations, there are some common considerations. Group members should be oriented to any special considerations that someone with a disability may require in order to effectively participate. Discussions about an individual's disability can be quite therapeutic and pertinent to the process of recovery, especially if the client has recently acquired the disability or has spent so much time under the influence that he has continuing adjustment problems associated with the disability. Consequently, treatment staff should encourage discussion of disability issues when clients bring them up.

Group members can be trained to assist in making accommodations for peers who have disabilities. It is important, however, to work with nondisabled clients to minimize their enabling of or overcompensation for people with coexisting disabilities. Describe to the group the practical aspects of helping the person with a disability, and ask that person to describe what she expects people around her to do. The concept of asking for help is congruent with many treatment approaches. However, for a person with less awareness or acceptance of her disability, it is important that peers are aware of what is appropriate help to offer.

When working with people with coexisting disabilities in a group counseling setting, counselors may find it useful to alter group participation expectations, limit the time in group, and work with the group to extend the group learning experience outside the confines of the group session. While the actual accommodations used will likely be tailored to each individual, there are some general strategies (discussed below) that have been successful in making group counseling more accessible for individuals with particular types of disabilities.

Finally, providers must consider and prepare to justify modifications to group counseling for billing purposes, especially with regard to Medicaid and managed care organizations. In most cases, billing for these services by the half-hour would be acceptable, although the standard unit of service is 1 hour. In some cases, counselors can conduct shorter sessions but bill for the entire session, which is appropriate because additional preparation time is needed for these modified group sessions.

Group counseling for people with sensory disabilities

People who are visually impaired need to orient themselves to the group in a different manner than those who are sighted. They will need to understand the group counseling environment, including the position of all the participants and the format or structure of learning activities such as reading assignments, so that they can prepare for them in advance. Other group members should be aware that they can not use eye contact to communicate with members of the group who are blind, and must rely on different methods. See Figure 3-7 for other suggestions of how to work with clients who are blind or visually impaired.

If a person who is deaf is using an interpreter, group members will need to take turns during discussions. If several people are talking at the same time, which is not uncommon for hearing people, the interpreter will be unable to communicate all the information. Requiring people to raise their hands before speaking is a good method to ensure that only one person is speaking at a time, as is deciding beforehand the order in which people will speak. In a group session the person who is deaf will normally be a few seconds or minutes behind the hearing group members; it will usually take longer to interpret a sentence than it took for the person to speak it. An interpreter must understand the context before interpreting and it may happen that a message will require more signs than words. The counselor should make a point of asking the group members who are deaf for their responses and questions in order to ensure that they are included in the discussion. If a session lasts more than an hour, two interpreters may be necessary, because signing is very fatiguing.

Even if staff members are fluent in sign language, other types of interpreters (i.e., a CART reporter) may be needed. Not all individuals who are deaf are fluent in sign language, and some, such as a person who is deaf and blind, may have very particular communication needs. The issues for the group process are similar in these instances, however. For example, the deaf or hard of hearing individual will get the message through CART slightly later than the hearing clients. The CART reporter will have the same difficulty as the sign language interpreter if hearing group members talk at the same time as one another. The biggest difference is that individuals who are deaf and do not use sign language generally prefer to be included in groups with hearing clients rather than being in all-deaf groups. These individuals have spent most of their lives with hearing peers and do not socialize primarily with other people who are deaf. Their identity is not tied to being deaf and using sign language.

Group counseling for people with cognitive disabilities

Accommodations for persons with cognitive impairments can include the use of visual cues, mixed media, and the repetition of major points. Expressive therapy, or the practice of using movement to express feelings, is also often effective for persons with mental retardation and other cognitive disabilities. Role-playing works well for persons with developmental disabilities—the process of playing a role themselves helps them to internalize it.

The use of verbal and nonverbal cues will help increase participation and learning for people with cognitive disabilities and make the group run more smoothly for all. People with cognitive impairments are often impulsive because they lack normal feedback mechanisms. They do not wish to be impulsive, but lack the ability to regulate this behavior for themselves. Therefore, counselors and peers should try to provide external cueing until the person can internalize it. The counselor and the person with a disability together can design the cues but should keep them simple, such as touching

the person's leg and saying a code word (e.g. "interrupting"). If cues are used in a setting where other people will observe them, alert the group to the cue in a matter of fact way as you would alert them to a use of a dog or the space needed for a wheelchair. Cueing can be useful for people with other types of disabilities and for other purposes as well.

For people with AD/HD, it is helpful to establish a maximum length of time, for example, 10 minutes, for presentations. Another modification to group counseling, which is beneficial for those with mental retardation or brain injury (as well as other clients), is to set aside 10 minutes at the end of the session to reinforce what occurred during therapy. Such discussion ensures that content is retained and promotes active rather than passive learning. Some people with cognitive disabilities may have problems with time management and will need to be reminded of group sessions with a phone call or a page.

Accommodations for disabilities can be made when developing goals and awards for successful participation in group counseling. It may be helpful to ask a person what he would like in recognition for accomplishing his goals. Something as simple as a certificate of completion may be an extremely important reward for a person with mental retardation. Utilizing token economies, such as the "medallions" given in a 12-Step program, may be another method.

It may be necessary to make changes to group learning activities in order to accommodate people with cognitive disabilities. The use of alternative media to replace traditional homework assignments involving reading and writing may be required. An individual who has an expressive language disorder may be unfairly judged as uncooperative in expressing feelings and participating in group process. However, given the opportunity to express herself through therapeutic artwork, she may communicate quite a bit.

Mixed media can be incorporated in other ways as well. As a group project, clients could work together to "draw the road to sobriety," depicting the pitfalls they might expect to encounter along the way, or work as a group to construct an image of a "sober city." Clients can create memory books or journals (to capture the content of sessions), or flash cards (of words or pictures) to jog memory for relapse prevention, perhaps presenting people and places to avoid. Clients can also design flash cards containing phrases that are meaningful to them to assist them when they are confronted with a situation that threatens their sobriety.

Counselors should not assume, however, that one person's experience will be understood by another, particularly in the case of a person with a cognitive disability. There may be a great deal of shared experience, but the person with a disability may not understand it unless it is made specific and pertinent to his own life.

Group counseling for people with physical disabilities

As a general modification, it is necessary to accept different types of body positioning for people with physical disabilities—some people may need to stand up or move during a group session, and this activity should not be considered rude. Counselors may have to keep group sessions short or schedule frequent breaks to help people who lack physical stamina and make allowances for increased travel time to meetings for people who use wheelchairs or rely on public transportation. Sometimes individuals with spasticity or other motor problems, such as those associated with quadriplegia, have voluntary or involuntary movements that are sudden and unusual for people not familiar with them. The counselor should ensure that group members are not distracted by these movements and understand

that they are a normal manifestation of some disabilities.

Medication Assessment And Management

The counselor should be aware that people with disabilities may be dependent on or inappropriately using prescription medications. Drugs are often perceived as providing comfort and managing the symptoms of a disability even while they are contributing to secondary complications. The routine of taking particular medications may itself provide feelings of control, stability, or safety. Additionally, some physicians prescribe medications in a palliative manner in an attempt to assist with disabilities they cannot cure (e.g., chronic pain, multiple sclerosis); unfortunately, the physician may not get proper feedback from patients regarding the efficacy of a given drug unless a patient is educated and motivated regarding the need to provide such feedback.

The Panel recommends that early in treatment, a medical professional conduct a medical examination and prescription assessment of all clients with coexisting disabilities. The medication assessment should review the consumption of both prescribed and over-the-counter drugs, including herbs and vitamins. The necessity for this review has increased in recent years because managed care has made it increasingly less likely that one physician will be writing or be knowledgeable about all prescriptions provided to a patient.

Learning self-advocacy and assertiveness with physicians and around the issue of health care and medication is important for people with disabilities. Persons with disabilities, like other individuals, may take a passive role during interactions with physicians, consequently receiving incomplete information about medications that are prescribed for them. Clients should also have a basic understanding of medication compliance (e.g., taking a medication regularly and on schedule, rather than just when the condition flares up). An important component of learning to live a sober life is to understand and properly use medications.

Treatment programs that care for people with disabilities have found it helpful to contract with a knowledgeable physician or a licensed pharmacist (Pharm.D.) to conduct medication assessments and review an individual's charts for possible drug interactions. The resulting information and suggestions can then be forwarded to medical authorities associated with the care of this individual. A licensed pharmacist often has a wider knowledge of drugs of many classes than most physicians, who may specialize in treating certain conditions and may only be familiar with a limited number of drugs.

Conditions such as diabetes, leukemia, and AIDS may require the use of medications that are self-injected or administered through a pain pump. Philosophically, self-injecting people may pose a problem for some drug treatment programs, but providers should keep an open mind. Under no circumstances should nonmedical treatment staff advise clients to take or not to take particular medications, vitamins, or herbs. Medication decisions should always be left to specialists. Staff should, though, become more knowledgeable about the purposes and potential side effects of medications taken by people with disabilities. TIP 26, *Substance Abuse Among Older Adults* (CSAT, 1998), reviews many of the medications used by people with disabilities.

Chronic Pain

Some people with disabilities experience recurring or chronic pain as a result of a disabling condition. The treatment provider must consider pain management as an important part of the rehabilitation plan.

Persons with chronic pain may enter treatment addicted to the medication that they are taking for the pain. In these cases, it is critical that the treatment plan involve a physician for consultation and medication management as well as knowledgeable rehabilitation specialists who understand alternative treatments for chronic pain.

Sobriety may not be attractive or desirable if it is associated with unrelieved pain. The treatment provider should explore with the client what pain management options have been tried in the past, and which alternatives seem to hold promise. The individual should be encouraged to discuss her feeling about pain and how it affects her daily life.

Accommodating chronic pain

There are a number of accommodations that a treatment provider must make for persons with chronic pain. Providers must attempt to determine if the pain is the real reason an individual has been using a substance; if it is, they will need access to a good alternative pain management program (preferably one accredited by the Commission on Accreditation of Rehabilitation Facilities) to help manage withdrawal. The substance use disorder treatment provider should not make these decisions alone, but in consultation with the rest of the treatment team and the client. Confirmation of the medical condition can be obtained with the individual's consent from the medical provider.

In cases of chronic pain it is critical to obtain an accurate pain therapy history for each person. That history should ascertain the amount of medication being taken and determine whether it is within the prescribed limits and whether or not more than one physician has been prescribing medications for the same or similar conditions.

Since most medications for pain management are abusable drugs, programs may need to alter their policies regarding the use of such drugs. In these cases, the client can be given a locked place to store medications on the premises; however, although it may be convenient to ask a person with chronic pain to leave his medication with the treatment staff for dispensing, this may not be legal in a typical, residential substance use disorder treatment program.

Alternative treatments for chronic pain

There are alternatives to the use of analgesic narcotics for chronic pain management that can be considered for people with disabilities who are in treatment for substance use disorders.

Acupuncture is one technique used to manage chronic pain. It is already used in some treatment programs for detoxification and to help relieve symptoms of withdrawal. Some anesthesiology departments now have an acupuncturist on staff, and the technique is gaining broader acceptance. Other alternative treatments for chronic pain include

- Physical therapy and exercise
- Chiropractic care
- A transcutaneous electrical nerve stimulation (TENS) unit
- Biofeedback
- Hypnotism
- Magnetic therapy
- Exercise
- Therapeutic heat or cold

Many of these therapies have limited or anecdotal support of their efficacy. The treatment provider will need to seek expert advice on their use for any person with chronic pain.

Aftercare

For people with disabilities, providers should begin thinking of aftercare options early on in treatment, as it may be difficult to find the necessary services in the local community. It is

important to understand that a person with a disability may require more sustained contact with aftercare resources than usual in order to enhance skill development, fulfill employment goals, or develop alternative social supports. Aftercare plans need to include provisions for counseling or relapse prevention groups, as well as other practical matters such as housing concerns or legal issues. Ideally, one professional within the treatment program or affiliated with some other community agency will be responsible for monitoring aftercare activities. If aftercare services are not reasonably accessible, treatment programs can direct clients to tape or book libraries, Internet sites, or other types of self-directed support activities. Again, the treatment provider should consider that clients with certain disabilities will require more structure and assistance than normal in order for the program to be effective.

Programs will need to make use of linkages in order to facilitate aftercare for people with disabilities (see Chapter 4). For example, a halfway house or other sober living arrangement can help extend support and structure over a longer period of time, which is particularly beneficial for people with disabilities. The ADA requires that halfway houses and sober houses be adaptable for people with disabilities, but in reality that is not always the case. The treatment provider should investigate whether accommodations will be made for a client with a coexisting disability before sending him to an aftercare facility. Even if a person is not going to an aftercare facility, treatment providers should make housing a priority and find out from the community network or other systems serving the person whether there is housing available and if it is appropriate.

Aftercare for People With Cognitive Disabilities

For individuals with cognitive disabilities, providers must systematically address what has been learned in the program and how it will be applicable in the next stage of treatment or aftercare. These clients can be very context-bound in their learning, and providers cannot assume that the lessons learned in treatment will be applied in aftercare.

The use of role-playing to rehearse what will happen at 12–Step-based meetings or in other aftercare settings can be a great help to all clients in treatment, not just those with coexisting disabilities. Someone with a cognitive impairment may find it extremely difficult to understand and complete all 12 Steps, but exposure to even a few of the steps can help her recovery. There are versions of the 12 Steps adapted for persons with brain injury, reading limitations, and mental retardation (although not all 12-Step members or groups agree on these modifications). Other modifications to 12-Step programs may also prove more beneficial to some people with disabilities. For persons with mental retardation, the presence of a facilitator may be very helpful, even though facilitators are not normally a part of 12-Step meetings.

People with disabilities face the same stigma and the same barriers in aftercare as they do in the rest of society. Individuals with mental retardation may be shunned or ignored in 12-Step meetings. They may not understand slogans or concepts or follow what is said in meetings. On the other hand, they may also find groups or individuals who can be very accepting. It may help if counselors find someone in a local 12-Step group willing to help someone with a cognitive disability connect with others in the group.

Perhaps one of the greatest risks for clients with TBI during aftercare is the difficulty of unstructured settings. While they may thrive in

highly structured day treatment or residential programs, they might be at high risk for relapse when they must self-structure their environments. After leaving formal treatment, a client with TBI might be unable to avoid high-risk situations, follow treatment recommendations, or find a ride to an AA meeting. The fact that the disability is often not obvious to staff, peers, or family members intensifies this susceptibility to the loss of structure that accompanies treatment discharge. Role-playing and other techniques that enable clients to prepare for upcoming high-risk situations will be very beneficial for people with TBI.

Aftercare for People With Sensory Disabilities

People who are deaf often leave home to attend one of a few inpatient treatment programs across the country and then return to their home States to receive aftercare. There they may find few resources available. Staff members should try to set up a comprehensive aftercare program in the client's home area that would offer education and support from local service providers. Ideally, after an individual has completed primary treatment, she will have access to a variety of aftercare resources, including self-help groups, a relapse prevention group, aftercare therapists fluent in American Sign Language, an interpreter referral center, vocational assistance, halfway houses, sober houses and other sources of assistance and support. Networking with other service providers both locally and nationally is an important activity in aftercare (see Chapter 4 of this TIP for more information on linkages with other programs).

It will be difficult for people who are deaf or hard of hearing to find 12-Step meetings where sign language interpreters are available. Even if they have an interpreter to assist them, many 12-Step terms are foreign to American Sign Language and require very competent signing to translate. If a person who is deaf doesn't know sign language, the situation becomes even more complicated. Professionals who work with people who are deaf have different answers to this problem. Some believe that even if no interpreter is present, a 12-Step meeting is at least a sober environment where the temptation to use may be reduced for some period of time. However, others believe that sitting in a meeting and being unable to communicate with anyone or understand anything that is said is of no use to the individual and can even be harmful. The individual could feel isolated in this situation, become frustrated and angry, and be more apt to use. Meeting attendance is an important issue for the counselor to discuss with a person who is deaf during treatment; the person needs to leave treatment with a realistic plan for how to deal with this issue. The possibility that a client may use her deafness as an excuse for not attending meetings should also be carefully explored.

One common pitfall of aftercare for clients who are blind is low expectations. Too often therapists expect too little from people with disabilities instead of making accurate accommodations to an aftercare plan. For example, if a person is expected to keep a journal but does not have a keyboard or is not Braille literate, he should use audiocassettes. If bibliotherapy is an integral component, the provider should research the availability of the material at the State's regional library for the blind or National Recordings for the Blind.

4 Treatment Planning and the Community: Linkages and Case Management

Because persons with disabilities often have multiple life problems, they may require services ranging from vocational training to medical care to assisted living. It is not unusual for services to be duplicated or ineffective when a case manager is not utilized, and so a substance use disorder treatment provider may have to either case manage these services or find another organization that can do so. A case manager can be a strong advocate for a person with a disability and help her locate appropriate and accessible services.

Treatment Improvement Protocol (TIP) 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT, 1998), suggests three different models for establishing linkages to provide for interagency case management. These include

- The single agency
- The informal partnership
- The formal consortium

In the *single agency* model, relationships with other agencies are established as needed to meet the needs of particular clients, with a single case manager retaining full control over the case. Often, this model is used to meet acute needs in a system where no partnerships have been established. While this model has the advantage of providing a single point of contact for the client, it may limit the array of services available and may require considerable time on the part of the treatment provider to establish a connection and reach a suitable arrangement.

In an *informal partnership*, staff members from several agencies collaborate as a temporary team to provide multiple services for clients, advising and consulting one another and exchanging information. No contractual mechanism is used in informal partnerships, which are readily constructed on a case-by-case basis. Such partnerships make more services available for the client and improve service coordination. However, breakdowns in service coordination are possible, and different problem orientations may lead to conflict among members.

A *formal consortium* links three or more providers through a formal, written contract. Agencies work together on an ongoing basis and are accountable to the consortium, usually with one agency taking the lead to ensure coordination. Case managers may be supported through resources pooled from members of the consortium or by the lead agency. Among the advantages of this approach are more opportunities for coordinating care, less duplication of services, and strengthened service integration. Disadvantages are that multiple agency participation may raise costs and

consortia take more time to organize and to respond to problems.

Providers must determine the type of organizational structure that will best meet the linkage goals they have identified. Considerations include the number of people with disabilities served, the regularity with which clients with coexisting conditions are served, the types of disabilities represented, the service providers most frequently accessed, financial considerations, and geographical and political factors within the community.

Providers must be prepared to act as advocates for their clients when services and supports that are normally readily available and effective prove inaccessible for the client. There may be physical barriers to access in other facilities, such as stairs and no ramp, inaccessible parking, or an elevator that is frequently nonfunctional. Other barriers may arise from policies or procedures that should be modified to take the client's disability into account; for example, the reliance on prescription medication may initially bar the client from 12-Step programs or halfway houses that require participants to be "drug free." Materials supplied by linkage agencies may be in inaccessible formats; for example, an agency might ask a client to pay for a set of resource materials in Braille or closed captioning on videotaped materials for people who are deaf or hard of hearing. To act as the client's advocate in such circumstances may require linkages with agencies that are familiar with the requirements of the Americans With Disabilities Act (ADA), other Federal legislation, and applicable State and local disability laws and regulations. With a stronger understanding of the ADA, agencies and their field workers can become much more confident and effective advocates for their clients. In addition, agencies should establish working relationships with legal services, law school legal clinics, civil rights pro bono offices, and attorneys in order to provide clients with needed legal assistance. There are many types of creative pro bono legal services available on a local, State, and national level for both the agency as an organization and the client as an individual.

While establishing additional linkages may seem an almost insurmountable barrier to overtaxed treatment agencies, they are essential to increase the effectiveness of substance use disorder treatment and recovery services for people with disabilities. A recent 3-year study of people with disabilities treated by the Anixter Center in Chicago demonstrated that even individuals with severe and multiple disabilities are successful in treatment and maintain sobriety if provided with modified treatment and case management services (Research Development Associates, 1997). Because many disabilities go undetected, successful outcomes for the treatment center may increase as providers build these linkages and use them to enhance their expertise and experience in identifying and accommodating disabilities. Furthermore, the techniques that enable providers to better accommodate people with disabilities can be readily applied to help them meet the varying needs of all clients with greater effectiveness and insight.

Building Linkages for Treatment Programs

Why Linkages Are Necessary

The following are among the most frequently cited goals that motivate providers to establish linkages. The specific goals that resonate most with the provider will drive the linkage model chosen, the specific partners who participate, the activities engaged in by the collaborative team, and the means of formalizing and maintaining the relationship.

To improve an individual's prognosis for recovery. As stated in Chapter 1, research

suggests that, for persons with disabilities in particular, issues such as lack of employment and social isolation contribute strongly to substance use. Linkages can address some of these problems, even when a client is unable to work on them in treatment. For example, most individuals who are deaf would benefit from a strong aftercare plan that connects them with an aftercare counselor in their community. Three factors that contribute to long-term sobriety following treatment for individuals who are deaf and hard of hearing are (1) employment, (2) having a friend or family member that they can talk to about sobriety, and (3) the availability of self-help groups such as Alcoholics Anonymous (AA) and Narcotic Anonymous (NA) (Guthmann, 1996). Linkages can help ensure that these additional services are available.

To ensure compliance with legal mandates. Legal mandates such as the ADA require treatment programs to be accessible for people with disabilities. Programs that are not accessible face the possibility of a class action suit from people with disabilities. Disability advocacy groups or consultants often have expertise to share on how to meet legal requirements. For example, one organization may review the policies and procedures, physical facilities, and communication strategies of another, identifying areas that may be in violation and suggesting means of coming into compliance.

To increase teamwork among providers in addressing advocacy issues. People with disabilities who have substance use disorders are subject to double discrimination and may face seemingly insurmountable barriers to treatment. Many are not able to speak effectively to their own needs. In such cases, the treatment provider can help identify appropriate resources and enhance the client's capacity for self-advocacy. Both at the client and community level, it is critical that members of the substance use disorder and disability treatment communities support one another in promoting advocacy for their clients.

To improve coordination of services. A person with a coexisting disability may be eligible for services from several agencies, which might provide similar, duplicate, or conflicting services concurrently. Services provided in a fragmentary way typically prove far less effective than those coordinated thoughtfully. By establishing a working relationship with disability resources—both on a case-specific basis and through ongoing coordination mechanisms such as task forces—the treatment provider can better serve the client. Interagency collaborations also tend to formalize case management services and ensure that these services continue in spite of staff turnover.

To access or leverage scarce financial resources effectively. Some people with disabilities are eligible for a range of services and funding from a variety of agencies, such as State vocational rehabilitation (VR) services, Centers for Independent Living (CILs), community mental health services, Department of Veterans' Affairs, Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), workers' compensation, physical rehabilitation, public transportation, public assistance, and managed care capitation programs for members of designated "risk pools." In order to ensure that people benefit from these services, treatment providers need to have linkages that will enable them to identify what may be available for their clients and how to access available services and funding.

An increased familiarity with disability-related resources in the community will also greatly help eliminate unnecessary expenditures for inappropriate accommodations or out-of-state services. For example, New York (a State that has obtained a Medicaid waiver) had to address the needs of persons with traumatic brain injuries (TBI), a small group that required extensive nursing home care. After providers

refused to serve these high-cost clients, the State referred them to out-of-state providers at $750 to $1,000 per day, for a total cost of $100 million yearly. A significant percentage of these persons also had substance use disorders. A provider aware of the problem, as well as alternative treatment options, pointed out how the cost of treatment could be reduced. The State obtained a home/community-based medical services waiver to allow individuals to receive services within the community. Substance use disorder services were reimbursed more generously than ordinarily allowed under Medicaid, and the total costs of providing care were greatly reduced. (See Chapter 5 for more information on funding treatment for people with disabilities.)

To identify appropriate accommodations and procedural modifications. Disability resource agencies can often help providers better understand the nature of people's impairments and identify strategies available to increase their functionality. To varying extents, people may effectively provide information on their own disabilities and the accommodations that have worked for them in the past. Some, however, may be newly disabled; may have had little opportunity to make informed decisions; or may be poorly motivated, due to low self-esteem or discouragement, to seek accommodations. Community linkages can help the provider determine whether or not a disability accommodation is needed. An example is a patient with a spinal cord injury who entered a treatment program that only allowed 10-minute breaks. The patient's bladder program sometimes took 30 minutes. When she explained the problem, it was viewed as treatment resistance and she had to leave the program (a clear violation of the ADA). Had treatment staff consulted a disability organization familiar with spinal cord injury, it would have recognized her legitimate need for accommodation.

Disability resource groups can help identify communication strategies or equipment that may be practical in a particular instance. They can also help treatment providers develop equitable policies and procedures, and materials in accessible formats for people with disabilities participating in treatment. Other benefits can accrue from such linkages (see Figure 4-1 for examples). Consultation should always occur early in the treatment to avoid the unfairness of last-minute adjustments. For example, a visually impaired person who needs materials in

Figure 4-1
Examples of Interagency Collaborations

- A treatment provider is provided space at a Center for Independent Living (CIL) to host a weekly sobriety support group that people with disabilities can attend during aftercare.
- A treatment provider purchases paratransit services to and from health care facilities at a negotiated rate so people can receive appropriate treatment for their disabilities.
- A CIL agrees to provide training to substance use disorder treatment staff on disability issues. This keeps CIL staff certification current and sensitizes treatment staff to the issues of people with coexisting disabilities.
- A disability law center agrees to draft policies related to ADA compliance for a treatment center on an ongoing, pro bono basis. This helps the treatment provider stay abreast of ADA-related requirements.

large print format should not fall behind while waiting for a resource or assignment others received the previous day.

Identifying Needed Linkages

It is helpful for people with disabilities if treatment programs take the time to analyze their current client base and determine the types of linkages and models that are most needed. Through formal surveys or informal meetings useful information can be gained, such as

- Number of people served with disabilities
- Types of disabilities people in treatment have had and the number of people with each disability
- Examples of disability-related barriers encountered and how they have been addressed
- Current retention and completion rates for people with disabilities
- Linkages used to address disability-specific problems, and their effectiveness
- Gaps in linkages that still need to be addressed

This information can be used to determine the areas in which disability-specific expertise or resources are required to more fully address people's needs.

Of course, if an initial assessment reveals the agency is not treating significant numbers of people with disabilities, the program should try to determine whether people are deterred by barriers that may not be apparent to the agency. The treatment agency should determine

- The number of its clients who might be expected to have disabilities on the basis of national or State incidence data and whether the actual number of clients with disabilities is lower than expected
- How it has publicized its services in the disability community, and how it might better serve people with disabilities through differently placed or more accessible outreach materials, or through direct contacts with disability advocacy and resource agencies
- Whether the agency is physically inaccessible or perceived as inaccessible
- Whether the agency's admission policies and procedures deter people with disabilities
- Whether the current assessment process is adequate to detect hidden disabilities that would commonly be missed

Having this information will make it easier for programs to identify their needs and present them to other organizations and agencies.

Locating Collaborative Partners

Most communities can help locate agencies to assist providers who want to treat people with disabilities effectively, and every State has a State Independent Living Council that can also provide information. Public health departments, the United Way, and county governments frequently produce directories of social, welfare, health, housing, vocational, and other services offered in the community. Sometimes they produce an automated directory. An excellent way to locate disability-related advocacy groups is to contact the State agency for vocational rehabilitation. Each office is mandated to have an ongoing consumer connection and should be able to assist in locating locally active service or advocacy agencies. Some of the agencies that may provide assistance to substance use disorder treatment programs seeking to work with persons with disabilities are listed in Figure 4-2.

Sources of Technical Assistance

Treatment providers need not be experts in all aspects of disability. There are a number of agencies available to provide specific information and assistance in these areas. The following key agencies are resources for general technical assistance on disability issues and can frequently provide referrals to linkage partners.

Figure 4-2
Potential Community Resources to Assist With Treatment

All Disabilities
- Centers for Independent Living
- United Way
- Vocational rehabilitation agencies
- State disability councils

Learning Disability (LD)
- Local or national Learning Disabilities Association
- Community, school, or university LD program
- Community mental health centers
- Literacy council

Developmental Disability (DD)
- School or community DD program
- Parent organizations
- Goodwill Industries
- Special Olympics

Blind or Visual Impairment
- Vocational rehabilitation providers
- Senior citizens' center
- Public library
- Society for the Blind
- Lion's Club

Deaf and Hard of Hearing
- Agencies for the deaf
- Vocational rehabilitation providers
- Senior citizens' centers
- State chapters for the Registry of Interpreters for the Deaf
- Commission for the Deaf and Hard of Hearing (located in numerous states)

Spinal Cord Injury
- Hospital rehabilitation programs
- Paralyzed Veterans of America
- Hospital or pain management program
- United Cerebral Palsy

Developed by D. Moore and J. A. Ford for the Rehabilitation Research and Training Center on Drugs and Disability (RRTC).

Complete contact information for many of them is provided in Appendix B.

- CILs—These nonprofit organizations are under the control of people with different types of disabilities. They are nonresidential and provide advocacy, information, independent living skills training, and peer counseling, among other services, for people with disabilities. CILs vary in terms of the scope of services they provide, number of staff and their areas of expertise, consumer groups served, and advocacy activities.

However, all share the goal of empowering people with disabilities to achieve the most independent lives possible. Many CIL staff will need training in identification and assessment of substance use disorders in order to function as effective partners. It is important to note that the term "Independent Living Center" (ILC) is also used by nonaffiliated centers that may provide different services, such as live-in facilities.

- Disability Advocacy and Service Groups—A wide range of advocacy and service groups are organized to serve persons who have specific disabilities or share a certain type of impairment. Their missions may be to provide training, consulting services, technical assistance, or resource material. Programs that begin working with a person who has a disability they have not yet encountered should consider contacting an appropriate advocacy and service group to ask for information, to explore linkage possibilities, or to locate specialized services.
- Vocational Rehabilitation Centers—Each State has an agency focused on providing vocational training and rehabilitation services to people with disabilities with the goal of placing these individuals into competitive employment. There are field offices located throughout each State and qualified professionals to work in an advocacy and case management role.
- Rehabilitation Research and Training Centers (RRTCs)—The National Institute on Disability and Rehabilitation Research (NIDRR) funds over 40 RRTCs devoted to specific disabilities or disability-related issues. Different RRTCs focus on topics such as spinal cord injury, traumatic brain injury, mental illness and long term employment, managed care, family issues, deafness, aging, or Native Americans with disabilities. (Appendix B lists contact information for NIDRR and selected RRTCs).
- Disability Business Technical Assistance Centers (DBTACS)—NIDRR has funded a network of 10 regional DBTACs. These centers provide information, training, and technical assistance to businesses and agencies covered by the ADA and to people with disabilities who have rights under the ADA. They are often well connected with disability resources and agencies within their region and can assist with referrals. In addition, they distribute a variety of resources pertinent to ADA compliance at cost or free of charge.

Building, Formalizing, and Maintaining Linkages

Once an agency identifies its needs and locates a potential partner, it can begin to lay the foundation for what may become a lasting relationship. Areas for collaboration can be identified and tested on an informal basis prior to confirming the linkage in binding agreements. For example, a relationship might be developed in stages such as the following:

1. The treatment center administrator or program manager reviews the needs of clients with disabilities, based on screening results at intake or referral information.
2. The program designated surveys community resources and agencies that provide services for people with disabilities and contacts personnel in these agencies to establish linkages.
3. The contacted agency assists in formulating treatment and recovery goals for the person with a coexisting disability. For example, a client and his counselor might attend an orientation session at a local CIL to determine what services are offered that he could use during aftercare.

4. During a period of informal information and service exchange, administrators determine whether cross-training activities for their respective staff members might be beneficial.
5. Other disability service providers are invited to participate in cross-training. For example, a resource fair of disability service organizations might be attended by treatment provider staff, or a representative of the treatment agency could give a briefing on substance use issues to staff members at a local halfway house.
6. If training or awareness activities are beneficial, and if services provided appear useful to the client, more formal ties with the disability service provider may be initiated to better serve future clients.

One organization that has effectively established strong community links is the Pima Prevention Partnership; it is described in Figure 4-3.

Formalized linkage agreements

Once relationships have shown themselves to be beneficial, they can be formalized through a written service agreement that outlines the duties and responsibilities of both parties. This type of document can articulate why and how the programs should work together, highlighting the benefits each party should

Figure 4-3
The People With Disabilities Project

The Pima Prevention Partnership, a federally funded substance use disorder prevention partnership in Tucson, Arizona, began including people representing disability service organizations on its Board of Directors. Board members became aware of the degree to which people with disabilities used substances and sought funding to address this issue community-wide. With grants from the Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP), the Partnership began a 3-year project to open treatment and prevention services for youth and adults with disabilities. The Partnership's activities to date have included

- Hosting a training session for the clinical coordinators of area substance use disorder treatment agencies to help them train their staffs on how to work with people with disabilities
- Hosting a larger training session for the staff of local substance use disorder agencies with the assistance of disability providers (including the local CIL, the Association for the Blind, the Community Outreach Program for the Deaf, and the Arizona Center for Disability Law) and a panel of recovering Tucsonians with disabilities who described the difficulties they encountered going through treatment without adequate accommodations
- Providing training for disability service providers on how to identify and refer substance-using clients and how to address their social and medical needs without enabling their substance use
- Developing case management procedures to ensure a coordinated approach to meeting client needs. Following their procedures, when a provider identified a client with a disability, the provider contacted the appropriate disability resource provider; when disability service providers encountered a consumer with a substance use disorder they referred the individual to a treatment agency.

Source: Kressler and Ward, 1997.

expect to derive from the relationship. Listed below are some examples of areas that might be addressed in such an agreement.

Substance use disorder treatment programs can provide

- Training and consultation on effective substance use disorder screening methods
- A referral resource for services agencies
- Training and consultation on the dynamics of substance use disorders and its intersection with other disorders and conditions
- Training on how to provide relapse prevention plans that also address disability concerns
- Case-specific consultation for people with substance use disorders

The disability resource agency can provide

- Assistance in modifying policies and procedures to avoid inadvertent discrimination
- Assistance with increasing accessibility for persons with disabilities
- Training for counselors to help them individualize treatment plans
- Access to specific programs, such as specialized employment programs offered through vocational rehabilitation agencies
- Support for people with disabilities in recovery who live in group homes or halfway houses

All agencies can

- Communicate at stated intervals to ensure consistency in coordinating treatment plans for mutual clients
- Conduct case consultations
- Conduct on-the-job training and cross training for staff

Of course, a formal agreement is no guarantee of a flourishing and productive relationship. Attention can be given to maintaining the established relationship through shared activities, such as the exchange of speakers, pursuit of joint funding opportunities, cross-training, and periodic meetings.

Linkages in Case Finding And Pretreatment

Case finding generates the flow of clients into treatment, often through formal liaisons with referral sources. Most individuals are referred to substance use disorder treatment by other agencies. A treatment program may use formal agreements with referral sources to create close partnerships and ensure that effective referrals are made so that clients do not fall through the cracks. For example, a treatment program might develop a contract with a hospital to do onsite evaluation of potential clients, whether they are visitors to the emergency room with mild head injuries or individuals who are newly disabled being discharged after acute care. Although many communities have informal referral networks created by individuals who know each other, partnerships are most effective if sought and maintained at the organizational level. (Several common referral sources and their functions are described in Figure 4-4.)

To make appropriate referrals, referring agencies should have a basic knowledge about the approach and procedures used by the treatment program, including admission criteria. In particular, for people with disabilities, they should know that the program is accessible and prepared to treat people with the disability in question. In order to ensure that different agencies have the requisite knowledge, it may be necessary to establish a formal training linkage that would involve staff cross-training.

A referral is effective only if the potential client contacts the treatment program. Ensuring that the contact occurs may be a task of the referring agency, the treatment program, or the client, depending in large part on the client's

Figure 4-4
Common Sources of Referral for Clients With Disabilities

Vocational Rehabilitation Agency: Provides training to prepare clients with disabilities to obtain and maintain competitive or supported employment. Such assistance may include prevocational training, such as building skills in grooming, punctuality, and interpersonal relations on the job. Specific training targets the client's desired job area.
Criminal Justice System: Clients with disabilities will be just as likely as other people with substance use disorders to face legal problems, and many referrals come from probation or parole officers, the public defender's office, and the police.
Hospitals, Physicians, and Emergency Rooms: Health care providers often encounter substance use disorders while treating people with disabilities for other medical conditions, including psychiatric conditions.
Centers for Independent Living: These nonresidential, nonprofit organizations run by people with different disabilities provide advocacy, information, skills training, and peer counseling for a cross-disability population.
Schools and Educational Agencies: Many substance use disorders become noticeable in an educational environment where a student's performance in different areas may be closely supervised.
Welfare Agency: Provides people with disabilities with access to Federal and State entitlement programs such as Supplemental Security Income, Social Security Disability Income, food stamps, general assistance, and Medicaid.
One Stop Job Shop (Career Center): Currently being set up in 33 States by the U.S. Department of Labor. Provides help in writing a résumé, searching for job openings on the Internet (America's Job Bank lists 750,000 openings by region and job skills), and using a computer.
Physical Rehabilitation Agency: Helps people to regain physical functioning after an illness or accident. These groups will have close contact with a number of people with disabilities.
Senior Citizens' Center: Offers a variety of social and community services to individuals age 65 and older. Services may include counseling and therapy, programming for persons with Alzheimer's disease, wellness programs, retirement adjustment programs, and meal delivery to homebound persons.
Family or Significant Others: Those closest to an individual are always an important source of referral for people seeking treatment for substance use disorders.
Veterans Affairs Program or Hospital: Serves active and nonactive military personnel and their families, providing them with medical and behavioral healthcare including residential treatment.

functional level and support network. In planning all treatment activities for clients with disabilities, it is critical to accurately assess their ability to be proactive and undertake activities on their own behalf. Some individuals with disabilities may become unnecessarily dependent on others. Others may insist on undertaking all activities, even ones that may prove to be beyond their capacity. For some clients, the referring agency need provide only a contact person's name and telephone number and then carry out a routine telephone followup. For others, a staff member from the referring agency may have to accompany the client to the treatment program and remain with the client through the initial phase of treatment. However

the first contact is undertaken, the manner in which it is achieved should be regarded as a critical first step toward treatment, and it should not be left to chance.

In developing partnerships with referring agencies, the treatment program should ensure, through interagency agreements, that mechanisms are in place for exchanging client information. The referral process is two-way, however, and the treatment program can also help clients with disabilities by connecting them with other services commonly available through programs for people with disabilities. To do this, programs need to maintain a resource directory of places to make referrals.

Linkages in Primary Treatment

Primary treatment is the period when a client is most actively engaged with the provider in treatment. During this period, many people with disabilities face challenges that may be addressed more effectively through well-chosen linkages. Whether the linkage is accessed through one-time arrangements or is incorporated into a collaborative treatment plan will depend on the treatment agency's policies and the extent of the client's needs.

Many people with disabilities will also have specific needs (such as the use of adaptive equipment) with which the treatment provider may not be familiar. Informed resources, such as disability advocacy groups, can help educate providers about these needs.

When treating clients with disabilities, counselors should be prepared to encounter additional complexities in some routine case management tasks as well as some new tasks and concerns. Because failure to recognize and address disability-related issues can seriously undermine treatment, the Panel recommends that early referrals to linkage agencies be made and that those services be provided concurrent with, rather than following, treatment. For example, because employment is likely to be a particularly challenging issue, realistic employment goals should be established early in the treatment process with the assistance of a vocational rehabilitation agency.

Numerous factors determine the type and level of adjustments required. Among the most obvious are the nature and severity of the disability, the length of time the individual has had the disability, the resources the individual has accessed to help him with the disability, the personal characteristics and skills of the client, his living situation, and his support systems. Linkages to other services may help to address and alleviate many of these problems. The following sections (and Figure 4-5) present some of the most common problems and the ways in which linkages can be used to help solve them.

Addressing Discrimination

As the client's advocate, the treatment provider may need to address discrimination specific to the individual's physical or mental disability, in addition to the discrimination that may occur due to a substance use disorder. The treatment provider should be able to determine if a discriminatory barrier has prevented a client from accessing a requisite service. When discrimination is encountered, the individual may need assistance from disability resource groups to develop and exercise self-advocacy skills. In some cases, intervention by the provider may also be required to ensure accessibility. Linkages in this area are extremely important because the treatment provider is unlikely to know how to advise or assist a client if the client experiences discrimination from another agency.

Linkage strategies

- Disability Business Technical Assistance Centers, Federal enforcement agencies, statewide protection and advocacy groups,

Figure 4-5 Common Needs, Their Impacts, and Possible Resources
Need: Medication management **Impact on Treatment:** The medication may cause the client to be disoriented or show symptoms of illness. **Resources:** Pharmacy, physician, nursing staff
Need: Self-care **Impact on Treatment:** The client may be unable to feed or dress herself, attend to personal hygiene, etc. **Resources:** Medical supply houses, nursing programs, attendant care, CILs, physical rehabilitation programs
Need: Cognitively accessible materials (understandable written and verbal materials) **Impact on Treatment:** The client may be unable to comprehend treatment goals and objectives, directions, training materials, or other important documentation in written form. **Resources:** Community mental health agency, Substance Abuse Resources and Disability Issues (SARDI), National Clearinghouse, school or college counseling service or disability office
Need: Equally effective communication (accessible counseling or training sessions) **Impact on Treatment:** The client is not able to participate fully in counseling sessions, lectures, meetings or training. **Resources:** Interpreters, computers, voice enhancement equipment
Need: Transportation **Impact on Treatment:** The client may be unable to arrive at counseling sessions on time or reach agencies to which she is referred. **Resources:** CIL, disability service office of public transit authority, county disability programs, volunteer assistance through United Way or other agencies, van pools, disability organizations, county ombudsman, Retired Senior Volunteer Program (RSVP)
Need: Housing **Impact on Recovery:** Because there is a shortage of low-cost housing that is also accessible, many people with disabilities otherwise capable of independent living may have difficulty locating a stable living situation. This may result in continued dependence on family members or caregivers whose attitudes and actions deter recovery. **Resources:** CILs
Need: Financial management **Impact on Treatment:** Clients with cognitive disabilities or mental retardation may not understand medical bills or benefits, resulting in a loss of services. **Resources**: CILs, community case management services

Legal Aid and other community-based legal services, CILs, and many disability advocacy groups may be able to provide clarification of legal requirements and documentation.

- Disability service groups can also help the client develop and exercise self-advocacy skills.

Disabilities Contribute to Substance Use Disorders

Disability-related issues can contribute to a substance use disorders and often must be addressed as part of the treatment process. For example, in the case of a recently acquired disability or one that is not readily apparent to the client, a client may need peer counseling or psychological counseling in the midst of treatment to help him deal with unresolved disability issues. The disability may have had a profound effect on the quality of peer relationships, job access, sexual function, and other areas—all of which may be relevant to recovery. The isolation, poverty, excess leisure, and low self-esteem that may accompany a severe disability may also have been factors in the development of the abuse pattern.

Linkage strategies

- CILs and community mental health centers may offer peer group and individual counseling, as well as an extensive array of information on disabilities.
- National or local organizations that work with people who have specific disabilities, such as the National Multiple Sclerosis Society, may also offer information or counseling services for people with disabilities.
- Individuals with recently acquired disabilities may need a mentor to help them learn to maximize mobility and access needed services.
- Some people with disabilities may benefit from self-advocacy skills and assertiveness training to enable them to be proactive and secure the resources they need. This training may be available through CILs, vocational rehabilitation agencies, and community mental health centers.
- Provider staff may be unfamiliar with nuances of behavior and concerns for people with disabilities. They may benefit from training provided by a collaborative partner with expertise in disability issues, such as a disability service group or CIL, in order to recognize and address these issues effectively in treatment.

Seeking Employment

A key area of concern for many people with disabilities is employment. It has been estimated that 60 to 70 percent of people with disabilities are either underemployed or unemployed (Taylor et al., 1986; LaPlante et al., 1997). Lack of employment may be a factor in substance use; conversely, addressing and overcoming barriers to employment, with the aid of collaborative partners, may greatly enhance the prospect for recovery and should be addressed as a component of treatment planning. For people with disabilities who have never worked, the lack of work skills and an employment history will be an added difficulty in securing employment.

Planning for full employment will be more challenging; in some cases it may even be an unrealistic goal. In some cases, the treatment plan may call for part-time work, volunteer work, or other activities that will enable the individual to experience achievement and appreciation. However, given appropriate accommodations and an imaginative approach to the job search process, many more people are employable than might at first be apparent.

Providers should be aware that successful sobriety and employment might mean the loss of medical or other benefits that are perceived as essential for survival. Providers should also recognize that there is an ongoing national debate about the appropriate public assistance policies for people with disabilities.

Linkage strategies

- State vocational rehabilitation agencies can provide coaching on resume preparation and

interview skills; they may also provide job training and purchase tools.

- CILs can provide help in developing job skills and finding employment.
- Employers with specialized hiring programs are excellent contacts. Employers who are able to hire large numbers of persons with disabilities, such as Goodwill Industries, may also be able to suggest other agencies.
- Local or State commissions may exist that address employment issues for persons with disabilities.
- The Job Accommodation Network provides free advice on accommodations for particular tasks (see Appendix B).

Common Needs of People With Disabilities in Primary Treatment

Clients with disabilities may have distinct needs that impact treatment and will need to be addressed through case management. Ideally, these issues should be considered by a multidisciplinary collaborative team, including a disability advocate, working together to address the client's needs. Figure 4-5 briefly identifies needs or issues that may arise, their possible impact on treatment, and resources that might assist the case manager in addressing these concerns.

Linkages in Aftercare

Because of the many situational factors that may facilitate or impede recovery, careful planning for aftercare is required and little can be taken for granted. Examples of key differences in aftercare likely to apply to many persons with disabilities follow:

- Ongoing and more frequent monitoring may be required, sometimes using different communication channels.
- Friends, family, and advocates are often especially material to the recovery of a person with a coexisting disability because of a higher degree of reliance on their care and support.
- The circle of people involved with recovery may be larger; for example, the support of attendants, residential facility staff, or home health care providers may be critical.
- Modifications to "typical" aftercare plans are likely to be required. Provisions for transportation and communication aides may be necessary.
- Service coordination and case management responsibilities are more prominent and time consuming than for clients without disabilities.
- The transition counselor for the referring program may need to brief outpatient program staff on the client's needs, functional limitations and capabilities, and suggest accommodations or modifications to usual procedures.

Using Linkages to Address Common Challenges

Developing interagency linkages

Accomplishing linkages to other agencies cannot be taken for granted, and additional steps may be required. Ballew and Mink (1996) identify five "tasks" related to linking that should be addressed prior to client contact with the resource agency (see Figure 4-6).

For people with disabilities it is important that the treatment provider not send the client to another agency for care without first checking to ensure that the client will be able to access the services. For example, in the process of rehearsing the plan described above, the provider may find that a lack of ramps, poor facilities for battery maintenance for wheelchairs, or inaccessibility to public transportation may be significant barriers for the client.

Specific problem-solving steps will vary from client to client; for some, it may be important to ensure that someone accompanies the client to

Figure 4-6
Five Linkage Tasks

1. Enhancing client's commitment to following through with contacting the resource
2. Carefully planning the client's initial contact with the other agency
3. Analyzing the potential obstacles that might hinder successful contact
4. Modeling and rehearsing the implementation
5. Summarizing for the client what was learned in steps one through four

Source: Ballew and Mink, 1996, pp. 235–236.

the first meeting. For others, a simple drawing of the route showing bus stop and ramp locations may sufficiently alleviate anxiety to enable the individual to make the connection without further assistance.

Linkage strategies

- Disability advocacy agencies may be able to suggest effective communication and memorization strategies.
- Alcoholics Anonymous intergroup offices should be able to identify meetings that are able to accommodate people with disabilities; however, all meetings should be visited first to ensure that this information is correct. Some local meetings may be willing to provide a guide or "buddy" to help the client attend and participate in meetings.
- It may be helpful or necessary for someone to take the client to a service agency. For example, this type of assistance may benefit persons whose cognitive impairments make it difficult to follow directions, and persons with mobility impairments whose concerns about accessibility may otherwise prevent their acting on the referral. This role may be taken by a designated anchor: a family member, friend, disability service advocate, church member, parole or probation officer, peer or mentor, attendant, health care worker, vocational rehabilitation staff member, caseworker, or volunteer.

Persons with disabilities on medication

The need for medication required because of a disability may mean that a client is not viewed as "clean." A client with a mental disability may rely on prescription drugs to stabilize mood and reduce the negative impact of the disorder; a client with a physical disability may depend on pain medication; and a client with epilepsy may use dilantin, a barbiturate-like drug, to control seizures. Some 12-Step programs may view such medications as a "crutch." Some halfway houses may also have policies that would deny admittance to people who are using these, or similar, medications (even though such policies are in conflict with the ADA).

A client's physician may inadvertently be enabling a client's substance use. A physician who is sincerely trying to help his patient might prescribe pain medication for a chronic physical disability rather than investigating alternate means of managing the pain. Other prescription medications can become drugs of abuse. For more information on the abuse of prescription and over-the-counter medications see TIP 26, *Substance Abuse Among Older Adults* (CSAT, 1998).

Linkage strategies

- Negotiate with "downstream" providers to ensure that services are available to people regardless of their medication use.
- Contact the American Society of Addiction Medicine to obtain the names of physicians knowledgeable about addictions; facilitate a consultation with the client's physician.
- Arrange for the treatment agency's staff physician to write a note to the private physician on followup planning and suggest a meeting.

- Work with health maintenance organizations to develop physician protocols that provide guidance on the distinction between enabling substance use and appropriate pain management.

Family and caregivers

Family and caregivers may be barriers to treatment rather than sources of support. For any number of reasons (e.g., to make life easier for themselves, to maintain current patterns of relationship) family members may contribute to the individual's continued substance use. In some cases, they may do so with the best of intentions. Because they feel sorry for the person who is disabled they may even encourage substance use as a way for their family member to feel better about herself (Schaschl and Straw, 1989). The family and other caregivers may also be overprotective of the individual and undermine the potential for a greater degree of independence. On the other hand, they may be weary from the strain of providing care and appear indifferent to the recovery process. For these reasons, family and caregivers should be included in treatment planning whenever possible.

Linkage strategies

- Family counseling services, provided through a community mental health agency, may help family/caregivers to function as effective "anchors."
- Families should be included in reentry planning through releases from the client.
- Recommend literature to families that addresses enabling behavior in general and for people with disabilities in particular. Disability resource agencies may be able to provide helpful literature.
- For some families federal money for respite care may be available.
- Information on respite care or respite services may be available through the State Unit for Developmental Disabilities, the United Way, and the Social Service Clearinghouse.

Isolation of client

Some people have experienced isolation because of their disabilities, and may have a relatively limited social circle. If isolation was a contributing factor in the development of addictive behavior, the return to relative isolation after the intensity of treatment is of even greater concern. Because the self-care and preparation required to leave home are time consuming and may produce anxiety, people with disabilities may have more difficulty going out to engage in social contacts. Clients who perceive options for social contact as limited may have particular difficulty refusing alcohol from friends who visit and assume that alcohol will be shared.

Linkage strategies

- Practical steps should be taken to connect the client with an accessible sobriety group or recovery community. It will be helpful to have someone available to accompany a client at first, or have him begin participating in these programs several weeks before he is discharged.
- For people whose interaction skills are limited, training in social skills or peer counseling may be helpful. Training may be available through CILs, community mental health centers, university disability student services, vocational rehabilitation programs, and programs for mental retardation and developmental disabilities.
- Establish connections with peer role models, especially those with disabilities, through 12-Step groups and disability advocacy/service groups.
- Some disability organizations, such as CILs, HIV agencies, American Council of the Blind Service Centers, and Department of Veterans' Affairs offices, offer support groups and social activities.

- Various community groups may sponsor substance-free picnics and parties.

Limitations of disability

A disability may limit the leisure activities available to a client. For those with moderate to severe disabilities, the nature of the disability may require special attention for identifying suitable leisure activities. Outside organizations can be extremely useful in finding or establishing such activities.

Linkage strategies

- If disability groups with whom the client is affiliated use alcohol as an integral part of social functions, the provider may offer awareness education (formally or informally) to encourage the provision of nonalcoholic alternatives. Many disability-related, community organizations would be willing to develop substance-free activities if they were aware of the difficulties faced by people with disabilities leaving treatment and trying to maintain sobriety.
- Providers should facilitate contact with local parks and recreation departments. Under the ADA, public parks and recreation are not permitted to exclude people with disabilities from events for which they are "otherwise qualified" or levy surcharges when they participate.
- Many groups offer challenging outdoor or sports activities specifically adapted for people with disabilities. Providers can contact groups such as the Blind Outdoor Leisure Development (BOLD), Wheelchair Olympics, and Wilderness International.
- The National Library Services for the Blind and Physically Handicapped can provide materials on recreational activities (see Appendix B). State and local libraries for the blind and physically disabled will also have resources available.

Uncertain client–employer relationship

Clients who are employed may wish to avoid involving their employer in a recovery plan for fear of jeopardizing employment. In some instances, the employer's policies may threaten recovery. While these are common client concerns, people with disabilities often have more difficulty securing employment, and thoughtful management of the return to employment may be especially important.

Linkage strategies

- DBTACs, local disability law centers, Equal Employment Opportunity Commission, and civil rights commissions or offices may provide legal counsel or information concerning employment issues.
- Encourage the client to use Employee Assistance Programs if they are available.
- Consider meeting with the employer to facilitate understanding of recovery needs (such as providing an alternative to alcohol at work-related events).

Longer monitoring period needed

More frequent monitoring over a longer period of time than is common may be required for people with disabilities. Creative strategies may be needed to ensure that monitoring occurs with sufficient frequency to identify relapse triggers in spite of funding limitations. For example, e-mail or automated telephone calls have been used to facilitate monitoring that requires less time than direct or face-to-face contact.

Linkage strategies

- Use a Community Health Rap, a line that enables the health professional to record answers to questions and make them available to others.
- Set up telephone support groups that enable people to access a telephone conference in lieu of a face-to-face meeting.

- Automated periodic telephone contact can be used to detect and prevent relapse; a telephone reminder system may be particularly useful for patients with memory impairments (Alemi et al., 1992).

Community Partnerships

Too often, the needs of people with disabilities who have substance use disorders are either not met at all or met inadequately. Many systemic factors can contribute to poor or nonexistent treatment. Because of these systemic barriers to treatment, many believe, as does Rebecca Sager Ashery, that case management must involve active community advocacy and systems intervention in order to be truly effective (Ashery, 1992). The activities of such a coalition could, she suggests, include

- Documentation of gaps in services
- Documentation of service duplication
- Examination of eligibility criteria
- Formation of a comprehensive referral network with formalized mechanisms of referral
- Development of communication channels between agencies
- Ability to merge services where needed
- Ability to address gaps in services
- Political advocacy for more resources and/or making changes in the service system
- Data collection and evaluation
- Quality assurance of programs

Substance use disorder treatment providers and disability service providers can and have worked together to meet one or more of these goals. For those seeking systemic change, a key step has been collecting data that demonstrate unmet needs. For example, data derived through screening people for disabilities may be useful in advocating for increased funding, particularly when several providers are able to offer similar data. Disability organizations may also be able to provide data on the prevalence of certain disabilities within a given area, adding specificity to estimates of unmet needs. Such data can be used to justify new risk pools and create functional carve-outs that benefit persons with disabilities who have substance use disorders. By sharing these data with decision-makers in managed care or public health policy, coalitions can help create an awareness of needs that may lead to enhanced resources.

Providers concerned with community advocacy may either start a task force from scratch or convince an existing task force to work to improve access to substance use disorder treatment for people with disabilities. Those who should be represented on such task forces will vary according to community characteristics and task force goals. Common participants include representatives of treatment programs, rehabilitation services, disability advocacy or service organizations, mental health agencies, volunteer organizations, funders, community leaders, and consumers of disability and substance use disorder treatment services.

Many providers have chosen to work through existing coalitions. Fortunately, in the arena of substance abuse prevention, many local coalitions exist throughout the United States whose mission is to reduce substance abuse in a community. (See Figure 4-7 for a few examples from the State of California.) These coalitions may be funded by local, State, or Federal sources or by private foundations. Many of these organizations have board members who are concerned about the prevalence of substance use in their community. However, members of these organizations are often unaware of the degree to which people with disabilities are affected by substance use disorders. Treatment providers who are able to demonstrate need and suggest specific activities that would benefit the community may persuade these already funded community coalitions to assist in making changes that will benefit people with coexisting disabilities.

Figure 4-7
Examples of Community Coalitions

The Disability Substance Abuse Task Force (now the Congress on Chemical Dependence and Disability)—Los Angeles County, California

- *Purpose:* To remedy the "unjust exclusion from alcohol and drug abuse services of people with disabilities" (de Miranda and Cherry, 1989).
- *Representative Accomplishments:* All Los Angeles County alcohol service delivery contracts now include specific language mandating that each program prepare a plan to increase its accessibility to people with disabilities. The County also requires all new treatment service programs to be fully accessible to persons with physical impairments

Disabled Access Coordinating Committee—Orange County, California

- *Purpose:* To ensure that alcohol treatment programs complied with Section 504 of the Rehabilitation Act of 1973.
- *Representative Accomplishments:* The committee conducted a needs assessment and facilities survey and is currently producing a series of recommendations to improve accessibility throughout the alcohol abuse services system.

Coalition on Disability and Chemical Disability—San Francisco Bay Area, California

- *Purpose:* To create a network of agencies that would document the need for appropriate services for people with disabilities in the area and to encourage creative coordination, networking, and cross-training among area alcohol, drug, and disability programs.
- *Accomplishments:* The coalition held a conference which included cross-training sessions and county caucuses to encourage advocacy, sponsored workshops on substance use disorder prevention among young persons with disabilities, and conducted a needs assessment to document the prevalence of drug use among persons with disabilities in the area.

Treatment providers interested in approaching existing coalitions may want to consider adapting the following step-by-step strategy:

1. Identify a local, countywide, or statewide effort whose mission it is to help reduce substance use (Mothers Against Drunk Driving, Governor's Alliances, federally funded community partnerships and coalitions, boards of large prevention and treatment agencies).
2. Develop and present (ideally in concert with a disability services provider) the issues of people with coexisting disorders.
3. Gain commitment to provide further education and training, including the development of a short-term action plan that includes constituency.
4. Evaluate how effective the partnership is in helping people with disabilities.
5. Publicize and reward the efforts of the coalition or partnership with public acknowledgment.

5 Administrative Tasks

While it is important for substance abuse counselors to understand the emotional and practical needs of individuals who are living with coexisting disabilities, program administrators also play an important role in their treatment, by ensuring that staff are properly trained and by modifying components of programs as needed. Substance use disorder treatment programs should take definite steps to improve treatment for persons with coexisting disabilities and be in compliance with accrediting agencies and regulations. Programs need to demonstrate an organizational commitment to assist those with disabilities; apply specific measures to eliminate barriers (either physical or procedural) to treatment; and develop treatment plans that take into account the particular needs and problems of people with coexisting disabilities.

There are definite legal and ethical motivations to modify programs to accommodate people with coexisting disabilities. Certainly, the Americans With Disabilities Act (ADA) is one motivator for this type of outreach (see Chapter 1 and Appendix D for more information on the legal ramifications of the ADA), but there are others (see Figure 5-1). The inclusion of people with coexisting disabilities will increase the diversity of a program and prove an enriching experience for all those involved. Expanding treatment to include people with coexisting disabilities presents a real opportunity to ask program funding sources for additional money, since there will be new people to be served who may be insurance or Medicaid reimbursable. Agencies should not, however, seek to serve clients with disabilities simply because they represent increased funding; this could lead to the provision of substandard services.

Additional services for people with coexisting disabilities should have a positive impact on substance use disorder treatment outcomes. For example, a program with a small percentage of individuals with traumatic brain injury (TBI) who are not completing treatment would likely show an improvement in overall treatment outcomes if they received appropriate services for their disability. Programs serving individuals with cognitive disabilities may find greater success rates if abstract concepts are simplified, and if reading and writing tasks are tailored to the cognitive level of the individuals.

Provider Knowledge of People With Disabilities

Substance use disorder treatment programs must become aware of their legal obligations and teach their staff some basic information about people with disabilities. Staff should understand, in particular, the factors that can affect a person's understanding of her coexisting disability, the many related problems that often accompany a disability, and the emotional responses someone might have to her own disability. Staff can learn about the needs of people with disabilities in several ways:

Figure 5-1
Benefits of Modifying Programs To Accommodate Persons With Disabilities

- **Improved treatment completion rates**
- New service population
- Legal compliance insulates program from liability
- Many grants and contracts are contingent upon Americans With Disabilities Act compliance
- Different funding sources available for a new population base
- Niche area or specialty area for the program
- Communities need to have this service available
- Expand scope of approaches and services to use with all clients
- Broader connection to disability agencies and the Disability Community provides political benefit

- Read this TIP and the resources cited in its bibliography.
- Train staff that substance use disorders are a disability and about the limitations imposed by the disabling characteristics of substance abuse and dependency.
- Participate in training that addresses the impact of physical, cognitive, sensory, and affective disabilities and the impact of a coexisting substance use disorder. Teach how those dual diagnoses affect significant others and family.
- Train staff concerning barriers to treatment for people with coexisting disabilities and how best to remove them. Such training should include, among other things, daily living skills strategies, information on the use of assistive devices, and ways to manage the living environment.
- Bring in outside providers with specialty in treating substance use disorders and disabilities to do in-service trainings. It may be helpful to use people with disabilities as trainers. Doing so will give the staff an opportunity to learn how to interact with people with disabilities and overcome their own prejudices and fears.
- Form resource networks with groups that focus on the needs of people with disabilities such as vocational rehabilitation programs, Centers for Independent Living (CILs), physical and occupational therapy providers, advocacy organizations, and developmental services. These organizations can be a source of staff training. (See Chapter 4, Treatment Planning and the Community: Linkages and Case Management, for more information on establishing linkages.)
- Train staff how to work with interpreters, how to use the Telephone Relay Service and Telecommunication Devices for the Deaf (TDDs). Staff should know how to access necessary people and devices. Telephone companies rent TDDs at a very low monthly rate, and some service centers located in a variety of states loan out equipment such as television decoders, visual alarm systems, and TDDs.
- Teach staff the proper etiquette to use with people who have physical and cognitive disabilities.
- Be sensitive to people with coexisting disabilities and consult them about their needs. Staff can learn a great deal from talking to them. While staff may feel it is impolite to inquire about a person's disability, consulting the person is necessary to provide appropriate accommodation. If a provider won't talk to a client about his disability, the client may get the idea that it is too shameful to discuss it.

For people with coexisting disabilities, as for any particular population, the higher the cultural competence of the program and staff in understanding the needs of this population, the higher the likelihood that they will be engaged and maintained in treatment. Persons with coexisting disabilities should be able to talk about their disabilities with program staff and feel understood and accepted. However, they should not have to feel that they must educate treatment providers about how to meet their needs.

Organizational Factors

A program demonstrates its commitment to working with people with coexisting disabilities from the top down. While there may be no substitute for a counselor's understanding of her clients, the counselor needs the support of her treatment program if she is to effectively apply that knowledge. It is the program that must demonstrate commitment if it is to attract persons with coexisting disabilities, and it is the program that is responsible, in the long run, for training its counselors to work with people with coexisting disabilities, and not the counselor who is responsible for educating the program.

Organizational Commitment

Policies and procedures

To ensure full organizational support for treating people with coexisting disabilities, the Consensus Panel recommends that a treatment program develop a policy statement that articulates the program's willingness to accommodate any individual with a disability who chooses to attend the program. Title III of the ADA requires that programs prepare a plan stating how they would serve a person with a disability. Therefore, the policies and procedures manual should be reviewed and revised to describe how the program would make an accommodation. Questions to address in the manual include: What is the process for asking for an accommodation and for assessing whether the program can make it? Who is responsible for instituting the process (asking for the accommodation)? Who decides whether the program can make the accommodation or whether it would impose an undue burden? What procedures should be followed when a person must be referred elsewhere for services?

A program's basic values and philosophy are reflected in its approach to a person whose impairment presents a challenge to the "standard" treatment plan. Treatment providers understand the anxiety most people experience when they make the first step toward getting help for an addiction, as well as the small window of opportunity that may exist to provide treatment. In response, many programs have developed formal or informal "open-door policies"; people who appear at such facilities without an appointment are seen, if only briefly, to arrange further care. An open-door policy means that no one is turned away or denied services. Instead, all people seeking treatment are assessed and a decision is made whether or not the program can meet the needs of the potential client.

However, many treatment providers' clinical experience has made them aware that treatment that is inappropriate for a person's current needs or situation may actually be harmful. For example, inappropriate treatment may use up a person's insurance resources while providing little or no gains in return. The sense of "failure" resulting from such unhelpful treatment may establish a precedent that the individual will use to justify avoiding treatment in the future. Indeed, the patient placement criteria of the American Society of Addiction Medicine, which are being used to define publicly funded care in several States, stipulate that if a program cannot provide a client with the necessary level of care, the program should not treat that client; instead an appropriate

referral should be made (American Society of Addiction Medicine, 1996). (See Chapter 4 for more information on the importance of linkages in referring individuals for treatment.) In developing a policy statement about the program's commitment to serve people with coexisting disabilities, administrators and staff should consider these issues.

Board membership

In making a commitment to treat persons from any particular population, one question that often arises is whether a member or members of that group will be appointed to the board of directors. The level of representation on the board (i.e., whether one or several members from a group are appointed) should, and sometimes does, reflect the proportion of that group in the treatment population. Many have argued that board membership of people with disabilities (or the lack of it) is a measure of the strength of a program's commitment, and that having several people with disabilities at this high administrative level will have a strong "cascade" effect on the program as a whole.

Others may feel that such mandates for board membership tie the hands of administrators and may not be the best way to ensure that the needs of all people with disabilities are met. For example, an individual appointed to the board who is blind may be effective in raising issues about persons who are visually impaired but not about persons with learning disabilities. As an alternative, some organizations form an advisory group or a task force made up of individuals who have different disabilities and chaired by a board member. However, some advocates may argue that task forces do not always produce real change. To be effective, an advisory group must have the ability to act upon its findings.

When a program makes a commitment to serve people with coexisting disabilities, board membership of people with disabilities may be implemented immediately or considered a goal to be reached as the program begins to serve a greater number of people from these groups. A program should try to obtain regular input from the community it seeks to serve, and creating a permanent task force or an advisory committee is an ideal way to address this need. But board members or advisory committees may have an important advocacy function without being experts on implementation, and programs will still need to obtain technical or consulting services related to specific disability issues.

Hiring persons with disabilities

Another sign of organizational commitment is to hire people with disabilities to work in the treatment program. Hiring people with disabilities also benefits other staff members, who can learn from these coworkers. Having such staff members can help sensitize others to issues, help differentiate between enabling responses and appropriate accommodations for people with coexisting disabilities, and provide encouraging role models for them. A person with a disability should not be assumed to be an expert on every type of disability and all disability issues, however. The extent of familiarity an individual will have with legal issues and the functional implications of disabilities will also vary according to that individual's background.

While it may not always be easy to find qualified staff who have disabilities it is worthwhile to actively seek such personnel. If a person with a coexisting disability is not available to serve as a counselor, a person with a disability (perhaps a former client) can still serve a function as a "client advocate" and act as a liaison between administration and clients.

Monitoring the program's efforts

The program must make a commitment to continually reexamine its effectiveness for people with coexisting disabilities. As knowledge concerning the treatment of people with coexisting disabilities grows, it is expected

that further changes to the program will need to be made. The main question to consider is, "Are we doing what is necessary to meet the needs of clients?" Such inquiry can take place formally, using quality assurance methods and consumer satisfaction surveys, and informally, using an anonymous suggestion box or by routinely asking clients whether their needs are being met.

One useful strategy is to routinely set aside a specific time at staff meetings to ask staff members for evidence that goals are being met, or not being met. For example, during a meeting at a therapeutic community, it might be asked whether the residents have been adequately apprised of the needs of a person with a disability who is scheduled to enter the community. Have they been given the opportunity to discuss how those needs might differ from other residents' needs? Has the incoming person been assigned to a "buddy" for peer support if that is the policy? Has the buddy received training or information in order to be sufficiently prepared? What specific steps are being taken to accommodate the new person's needs? For example, have certain household tasks been modified so that they can be performed by the new resident?

Staff Training

One concept that has remained largely unchanged in the treatment field is the importance of the bond that forms between a client and a counselor or group leader when the client feels understood and accepted. Without such bonds, it is difficult for a person to summon the commitment and courage needed to undertake recovery. In order for this understanding to develop the counselors must have knowledge of the particular needs of their clients. Staff training is essential to ensure this communication and understanding.

All program staff should be trained to understand functional limitations and capacities, the wide variety of conditions that lead to them, and the barriers that treatment-as-usual may present for persons with specific disabilities. Without this training, true organizational change cannot occur. Training modules using didactic and experiential methods have been designed for staff at all levels, including managers, program and clinical directors, clinical staff, and support staff. One approach is to provide a "disability awareness experience" in which staff role play and take on a specific disability for a period of time during which they have to do what is expected of the clients. In this manner they experience first-hand the problems, issues, and barriers a person with a disability might face, and can gain a better understanding of what it is like to have a decreased or altered level of functioning. At all levels of the program, training should strongly encourage and reward staff members who find creative ways to adapt treatment procedures for people with coexisting disabilities. A variety of disability organizations in the community can assist the program with training by providing materials and speakers. (For more information, see Appendix B, Resources for Information About People With Coexisting Disabilities.)

As with all groups who have been isolated and stigmatized, stereotypes and myths about people with disabilities abound, and fears may distort staff members' perceptions. A good training program will begin by eradicating such myths and replacing them with knowledge, skills, and a welcoming attitude. Staff should be encouraged to express their fears and to examine their beliefs. (See Figure 5-2 for some questions staff may wish to consider when examining their disability-related beliefs.) This initial training for all staff should be followed with more specific and specialized training focusing on different disabilities, the functional limitations associated with those disabilities, and possible treatment modifications and accommodations. Sometimes a brief staff training to address the needs of an individual

Figure 5-2
Questions for Counselors To Think About

- What books about people with disabilities did I read as a child?
- What view of people with disabilities do I get from the media?
- What scholarly information have I read concerning people with disabilities?
- What experience have I had with significant others who are disabled?
- Who else from the Disability Community have I had contact with?
- What are my issues, hot spots, fears, and stereotypes concerning disabilities?

slated to begin treatment helps bring an immediacy to the situation, which is beneficial.

Considering how pervasive some coexisting disabilities are within treatment populations, staff training in this area should also be ongoing and involve staff sharing their experiences in working with people with disabilities. In addition, with training, staff will become increasingly aware of the hidden disabilities of clients with whom they are already working. The program will benefit from this clearer clinical picture of the treatment population, and improved treatment outcomes can result.

Training of support staff is also important since these staff members are often a person's first contact with the program. A potential client's initial conversation with a receptionist or other support staff often forms her perception of the program. The success or failure of these interactions often determines whether or not the intake interview occurs at all. A warm and friendly reception is important for any person taking the difficult step of seeking substance use disorder treatment, especially for someone with a disability worried that he will not be accommodated. The message from the first contact should be upbeat, proactive, and geared toward allaying the person's anxiety and creating an initial bond. Receptionists and other support staff should receive special training to prepare them to respond knowledgeably and sensitively to people with coexisting disabilities; they should have the necessary practical skills, such as the ability to use a TDD or other common assistive devices, and a knowledge of basic disability etiquette.

Funding Mechanisms

Treatment for substance use disorders can often involve multiple funding streams, and treatment for people with coexisting disabilities may add new complexities, as well as opportunities, to the process of securing funding. Services may acquire funding from a variety of sources, including

- Block grants from Federal agencies
- Medicaid, which includes options that allow for nonmedical services (e.g., the Medicaid rehabilitation option)
- Medicare and Supplemental Security Income for people with disabilities
- Migrant health funds
- Private organizations, such as United Way
- Veterans services
- Developmental services
- Local tax dollars
- Private foundations

To provide sufficient funding for the longer and more complex supports that may be required for a person with a coexisting disability, blended funding is highly recommended. When several agencies have a mandate to provide care, as is the case for many people with coexisting disabilities, each may have access to funds for case management. Alone, no one agency may have enough funds to address the demanding case management

issues that could arise in treating persons with multiple or severe disabilities. However, blending funding may enable the coordinating team to create a pool of funds sufficient to fund a single case manager at an acceptable level.

Programs might consider collaborating with rehabilitation and other providers to share resources. For example, a substance use disorder treatment program might carry educational and treatment services into a vocational rehabilitation site. Carry-in services reduce the overall cost of separate programs and may, in certain cases, allow for third-party payment for both providers. In these cases, there is not a blending of funding, but rather a sharing of costs and a potential for mutual billing. (See Chapter 4 of this TIP for more information on the establishment of linkages that could be used to create blended funding.)

With low-incidence populations such as individuals who are deaf or hard of hearing, it may be more cost effective for States to use regional programs where fluently signing staff and interpreters for nonfluent staff are readily available. In some of the more rural States, there may not be enough individuals requiring treatment at any given time to have a separate, statewide program. But even in a well-populated State like New Jersey there has been a call for the use of out-of-state services (see Figure 5-3).

Funding Under Managed Care

For people with coexisting disabilities, managed care policies can pose a serious barrier to getting the level of treatment they require. Examples of managed care policies or limitations that could adversely affect clients include

- Lack of access to Health Maintenance Organizations (HMOs)
- Being placed on a waiting list by public HMOs
- Loss of funding due to capitation policies when treatment is required over long time

Figure 5-3

Out-of-State Specialized Services in New Jersey

Beginning in the late 1980s, New Jersey began developing services to meet the needs of persons who were deaf and hard of hearing and had substance use disorders. A statewide coordinator was hired by the Single State Agency, and funding was sought in order to begin developing a continuum of services for this population. There was a great deal of discussion involving referring agencies and individuals' families about how to meet the immediate need for residential treatment, and a decision was made to approve the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals as a New Jersey Medicaid provider. The reasons for this decision were twofold. First, this was the only hospital-based residential treatment program designed specifically to meet the needs of people who are deaf and hard of hearing. Secondly, this high quality program offered services that were more cost effective than what could be offered in New Jersey at that time. The daily cost was between two and three hundred dollars; a "hearing" program in New Jersey utilizing the services of sign language interpreters throughout the day and evening (to make the entire program accessible) would have easily cost twice as much. Additionally, a hearing program with interpreters would not work as effectively for most people who are deaf as would a program designed specifically to meet their linguistic and cultural needs. This cooperative relationship between agencies within one State and with an out-of-state, disability-specific program resulted in a more cost effective and higher quality solution.

- Restrictions on needed ancillary medical or physical care
- Not being allowed to use accessible treatment options

Poor self-advocacy skills, often coupled with low self-esteem, may impair a person's ability to "push" the system in order to get the care she needs. A case manager may have to either find strategies to overcome the adverse effect the managed care provider's policies have on the client or seek to change those policies through direct communication with the managed care agency. Managed care agencies should be held responsible for the effect of their policies on client outcomes.

For example, some managed care treatment programs use capitation to identify and contain costs for particular disability groups. Due to decreased stamina or other disability issues, some individuals benefit more from a program of lower intensity but longer duration. Preliminary research data indicate that some clients with disabilities may require more extended treatment—from several months to over a year longer—but with no more than standard outpatient intensity (Hser et al., 1988; Drake et al., 1996). For this reason, the treatment provider may find it necessary to document the client's unmet needs and negotiate managed care waivers or special plans to improve chances for a positive outcome.

By documenting and communicating the accommodation needs of people with coexisting disabilities, providers can sometimes persuade state officials to make systemic changes that will benefit these clients, increasing positive outcomes and thereby benefiting their communities as well. For example, in New York State, where everyone applying for public assistance is screened for substance use disorders, 18 million dollars are set aside annually for treatment. Such functional "carve outs" can also be used to address the need people with coexisting disabilities often have for extensive and extended case management services to facilitate their recovery. Treatment providers should have a thorough knowledge of the rights of people with disabilities in order to recognize when managed care policies are discriminatory and not in compliance with the ADA.

Marketing the Program

It is not enough for a program to simply be ready to serve the Disability Community. Rather, the program should be proactive in making the Disability Community aware of its services, to ensure that disability organizations will support referrals to the program. It is hoped that any program that makes a commitment to treat people with coexisting disabilities will be in contact from the outset with a variety of disability organizations in the community. Staff members should be available to present their agency and its willingness to provide services for people with disabilities at the meetings of disability organizations, thereby providing a personal contact for referring staff. Of course, the best advertisements for a program are people with successful treatment outcomes.

Outreach

Outreach materials should assure potential clients that an agency is able to provide accessible, appropriate substance use disorder treatment for people with coexisting disabilities. In addition to stating that accommodations and alternative communication strategies can be provided as needed, providers may wish to assure people with disabilities that they are welcome by including the universal accessibility symbol on their literature.

There are many facets of an outreach program that can be modified to accommodate the needs of people with coexisting disabilities:

- Tailor marketing materials, including signage, messages, brochures, and yellow

pages advertisements to people with disabilities. Have all such materials state that accommodation is available.

- If the treatment program is committed to serving persons who are deaf or hard of hearing, have a dedicated line for a TDD, and have that TDD number printed on all outreach materials.
- Create and use mailing lists of organizations that work with people with disabilities.
- Conduct specialized presentations and cross-training to organizations that serve people with disabilities.
- Offer substance use disorder training for the Disability Community at large.
- Adapt conference exhibits to show the program's accessibility for people with disabilities.
- Recruit people with disabilities to the board of directors and staff positions.
- Establish service agreements (e.g., agreements with organizations to provide a learning styles inventory for people with cognitive impairments).
- Link with particular disability groups for their expertise and to create training opportunities for the treatment staff.
- Encourage organizations that represent people with disabilities to conduct outreach to a variety of cultural and ethnic communities.

Substance use disorder treatment providers can establish a relationship with a colleague or more experienced clinician who is familiar with the Disability Community to assist in outreach planning. This individual can help interpret unfamiliar terminology for the treatment provider. Since neither party is an expert in the other's field, there is an excellent opportunity for an equitable relationship in which each party learns from the other. Centers for Independent Living are required, for example, to provide information, referral, and advocacy services. However, there are currently no existing mentorship programs or recognition of this need by national organizations. In addition to mentorship, providers can form or participate in an existing network that is disability-specific.

In making an effort to connect with other fields, programs must consider why other providers would want to collaborate. A key motivating factor for other groups of providers is the ADA, because they must also accommodate persons with substance use disorders. What is important is that linkages begin to be developed; it will, of course, take time for these relationships to be perfected.

Considering the high incidence of substance use disorders among people with disabilities, it is extremely important for substance use disorder treatment providers to be aware of this population's needs. Every treatment provider should expect to have clients for whom they will need to make accommodations, but many of these accommodations will not require extensive or expensive changes. Perhaps even more importantly, making accommodations and adapting treatment for people based on their functional limitations should improve treatment outcomes overall and should enable the program to provide better services to all clients. Better outcomes and improved services should result in more referrals and more satisfied customers.

Appendix A
Bibliography

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Appendix B
Information Resources

Substance Use Disorder Resources for Persons With Disabilities

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals

2450 Riverside Avenue
Minneapolis, MN 55454
800-282-DEAF (3323) (voice/TTD)
612-672-4516(fax)
MnCDDeafHH@aol.com

This program provides inpatient and outpatient substance use disorder treatment services for persons who are deaf or hard of hearing. In addition, the program provides specially developed treatment and prevention materials including a manual of specialized treatment approaches. It provides training about the delivery of substance use disorder services to deaf and hard of hearing persons. The program also receives Federal grant money to provide training opportunities to individuals who work with vocational rehabilitation. The program has a free catalog of materials on substance use disorders that are accessible for individuals who are deaf and hard of hearing.

National Association on Alcohol, Drugs and Disability

2165 Bunker Hill Drive
San Mateo, CA 94402-3801
650-578-8047 (voice/TDD)
650-286-9205 (fax)
http://www.naadd.org/

The NAADD is a membership organization dedicated to improving prevention and treatment services for people with disabilities. It operates a web site and publishes the newsletter *The Report on Alcohol, Drugs and Disability*.

New Jersey Coalition on Disabilities and Addiction

c/o Substance Abuse Resources
1806 Highway 35
Oakhurst, NJ 07755
(732) 663-1800 (voice)

National Rehabilitation Hospital

ADA Health Care Facility Access Project
102 Irving Street, NW
Washington, DC 20010-2949
(202) 877-1000 (voice)
(202) 877-1450 (TDD)

Pacific Research and Training Alliance (PRTA)

Alcohol, Drugs and Disability Project
Suite 401
440 Grand Avenue
Oakland, CA 94610-5085
510-465-0547 (voice)
510-465-2888 (TDD)
510-465-0505 (fax)

The PRTA provides technical assistance to all publicly funded substance use disorder programs in California working on disabilities and accessibility. It is working on a statewide project to assist substance abuse prevention, treatment, and recovery service providers in meeting the needs of clients with disabilities. Under this project, the PRTA works with providers from both the disability field and the substance use field. It is also developing a model substance use disorder prevention program for female adolescents with learning or physical disabilities. In addition to the documents PRTA has developed, it has an extensive library of training curricula, articles, research documents, and videotapes. Materials are available to the public.

Pima Prevention Partnership

People with Disabilities Project
Suite 105
300 North Main Street
Tucson, AZ 85701
(520) 623-8871 (voice)
(520) 623-8841 (TDD)
(520) 623-8817 (fax)

Rehabilitation Research and Training Center on Drugs and Disability (RRTC)

Wright State University
School of Medicine
P.O. Box 927
Dayton, Ohio 45401-0927
(513) 259-1384

The RRTC conducts research that focuses on the relationship between substance use disorders and the vocational success of individuals with disabilities. It conducts epidemiological studies, evaluates model systems, and provides training and technical assistance. It is funded by the National Institute of Disability and Rehabilitation Research (NIDRR), the Office of Special Education and Rehabilitative Services (OSERS), and the Department of Education.

SARDI Project: Substance Abuse Resources and Disability Issues

SARDI
Wright State University
School of Medicine
P.O. Box 927
Dayton, OH 45401
(937) 259-1384 (voice/TTD)
(937) 259-1395 (fax)

The SARDI project provides direct, disability-specific substance use disorder and disability prevention, intervention, and treatment services. SARDI conducts educational training with agency staff to enhance knowledge and awareness of substance use and disability issues. SARDI can provide several resource materials, or refer people to other existing materials. Some of SARDI's resources are listed above in references.

SARDI is also the home of the federally funded Rehabilitation Research and Training Center (RRTC) on Drugs and Disability, funded by NIDRR.

Federal ADA Enforcement Agencies

Architectural and Transportation Barriers Compliance Board: The Access Board

Suite 1000
1331 F Street, NW
Washington, DC 20004-1111
(800) USA-ABLE (voice)
(800) 993-2822 (TTD)
(202) 272-5434 (voice/TTD)
(202) 272-5447 (fax)
(202) 307-5448 (BBS)
http://www.access-board.gov

An independent Federal agency that developed the ADA Accessibility Guidelines and other architectural accessibility guidelines for the Government, the Access Board enforces UFAS but not ADAAG standards. It provides technical assistance and information on the architectural requirements of the ADA and other access-related legislation, and architectural, communication, and transportation accessibility. The Access Board provides a list of free publications upon request.

Equal Employment Opportunity Commission (EEOC)

1801 L Street, NW
Washington, DC 20507
Complaints and Information
(800) 669-4000 (voice)
(800) 699-6820 (TTD)
Documents/Public Information Center
(800) 669-3362 (voice)
(800) 800-3302 (TTD)
(513) 791-2954 (fax)
(800) 669-4000 (referral to regional offices)
http://www.eeoc.gov

EEOC is responsible for developing and enforcing the ADA employment regulations. It investigates charges of employment discrimination and works to resolve problems through conciliation. The 800 referral number also provides information on discrimination laws in English and Spanish. The EEOC provides free technical assistance publications on request.

Department of Justice (DOJ)

Civil Rights Division
Disability Rights Section
P.O. Box 66738
Washington, DC 20035-6738
(800) 514-0301 (voice)
(202) 514-0301 (voice)
(800) 514-0383 (TTD)
(202) 307-1198 (fax)
(202) 514-6193 (BBS)
http://www.usdoj.gov/crt/ada/adahom1.htm

Numbers listed are information lines on the ADA and the regulatory process.

The Equal Employment Opportunity Commission and the Department of Justice have jointly produced the *Americans With Disabilities Act Handbook*. This comprehensive publication provides background, summary, rulemaking history, overview of the regulations, section-by-section analysis of comments and revisions, P.L. 101-336, and annotated regulations of Titles I, II, and III. It includes appendices and related Federal disability laws. One copy is available free upon request from EEOC or DOJ or from the Disability and Business Technical Assistance Centers. Multiple copies can be purchased from:

U.S. Government Printing Office
Superintendent of Documents
Mail Stop: SSOP
Washington, DC 20402-9328
(202) 783-3238 (voice)
(202) 512-1426 (TDD)

Department of Transportation

400 Seventh Street, SW
Washington, DC 20590
Federal Highway Administration:
(202) 366-3764
http://www.dot.gov
Federal Transit Administration:
Documents and Questions
(888) 446-4511 (voice)
(202) 366-1656 (voice)
(800) 877-8339 (TTD)
(202) 366-7951 (fax)
Legal Questions
(202) 366-4011 (voice)
(202) 366-3809 (fax)
Complaints and Enforcement
(202) 365-2285 (voice)
(202) 366-0153 (TTD)

The Department of Transportation developed and continues to enforce the regulations to implement the transportation requirements of the ADA. It provides, upon request, information on the Title II and Title III requirements for public and specified private transportation, and publishes the Paratransit Handbook.

Federal Communications Commission (FCC)

Office of Public Affairs
Suite 1000
1919 M Street, NW
Washington, DC 20554
Documents and Questions
(202) 418-0190 (voice)
(202) 418-2555 (TTD)
Legal Questions
(202) 418-2357 (voice)
(202) 418-0484 (TTD)
Complaints and Enforcement
(202) 632-7553 (voice)
(202) 418-0485 (TTD)
http://www.fcc.gov

FCC developed and continues to enforce the regulations to implement the Title IV telecommunications requirements, such as those requiring relay services. It provides technical assistance and produces publications (available in print only).

Federal and Federally Funded ADA Technical Assistance Agencies

Administration of Developmental Disabilities

370 L'Enfant Promenade, SW
Washington, DC 20447
(202) 690-6590

Clearinghouse on Disability Information

OSERS/U.S. Department of Education
Room 3132, Switzer Building
330 C Street, SW
Washington, DC 20202
(202) 205-5465 (voice)
(202) 732-1252 (fax)

Job Accommodation Network (JAN)

West Virginia University
P.O. Box 6080
Morgantown, WV 26506-6080
ADA Information
(800) ADA-WORK (voice/TDD)
Accommodation Information
(800) 526-7234 (voice/TDD)
(304) 293-5407 (fax)
(800) DIAL-JAN (Computer Bulletin Board System)
janweb@icdi.wvu.edu
http://janweb.icdi.wvu.edu/

A service of the President's Committee on Employment of People with Disabilities, JAN is an international, free consulting service that can provide information about job accommodation

for people with disabilities. It helps solve specific job accommodation problems through its toll-free hotline.

Library of Congress National Library Service for the Blind and Physically Handicapped

1291 Taylor Street, NW
Washington, DC 20542
(800) 424-9100
http://www.loc.gov/nls

MRI/Penn Research and Training Center on Vocational Rehabilitation And Mental Illness

Matrix Research Institute
University of Pennsylvania Department of Psychiatry
6008 Wayne Avenue
Philadelphia, PA 19144
(215) 438-8200
http://www.matrixresearch.com/

National Institute on Disability and Rehabilitation Research

U.S. Department of Education
Room 3060
330 C Street, SW
Washington, D.C. 20202
(202) 205-8134
http://www.ed.gov/offices/OSERS/NIDRR

National Institute on Neurological Disorders and Stroke

Building 31, Room 8A06
31 Center Drive, MSC 2540
Bethesda, MD 20892-2540
(301) 496-5751 (voice)
(800) 325-9424 (voice)
(301) 402-2186 (fax)
http://www.nih.gov.ninds

National Research and Training Center on Psychiatric Disability

University of Illinois–Chicago
Suite 900
104 South Michigan Avenue
Chicago, IL 60603-5901
(312) 422-8180
http://www.psych.uic.edu/~rtc/

President's Committee on Employment of People With Disabilities

3rd floor
1331 F Street, NW
Washington, DC 20004-1107
(202) 376-6200 (voice)
(202) 376-6205 (TDD)
(202) 376-6219 (fax)
http://www.pcepd.gov

The President's Committee on Employment of People with Disabilities is a nationwide organization of 600 volunteer members that works to build and maintain a climate of acceptance of people with disabilities in the work force. It can assist in locating State governors' committees and local mayoral committees that address disability issues. It produces technical assistance materials, including videotapes, public service announcements, and fact sheets, and provides information on job accommodation, assistive technology, tax incentives, and other topics. A list of publications can be obtained by calling the above numbers.

Rehabilitation Research and Training Center for Persons Who Are Deaf or Hard of Hearing

University of Arkansas
4601 West Markham Street
Little Rock, AR 72205
(501) 686-9691
http://www.uark.edu/depts/rehabres/

Rehabilitation Research and Training Center on Blindness and Low Vision

Mississippi State University
P.O. Drawer 6189
Mississippi State, MS 39762
(601) 325-2001
http://www.msstate.edu/dept/rrtc/blind.html

Rehabilitation Services Administration

U.S. Department of Education
Switzer Building
330 C Street, SW
Washington, D.C. 20202-2500
(202) 205-5482
http://www.ed.gov/officers/OSERS/RSA/rsa.html

Research and Training Center on Rehabilitation for Persons With Long-Term Mental Illness

Boston University/Sargent College
Center for Psychiatric Rehabilitation
930 Commonwealth Avenue
Boston, MA 02215
(617) 353-3549
http://web.bu.edu/SARPSYCH/

Research and Training Center on Community Integration of Individuals With Traumatic Brain Injury

Mount Sinai School of Medicine
One Gustave L. Levy Place, Box 1240
New York, NY 10029-6574
(212) 241-7917
http://academic.mssm.edu/tbinet/

Research and Training Center on Community Living

University of Minnesota
College of Education and Human Development
Institute on Community Integration
RTC on Residential Services and Community Living
150 Pillsbury Drive, SE
Minneapolis, MN 55455
(612) 624-5005
http://www.ici.coled.umn.edu/ici/rtc/

Research and Training Center on Improving Community-Based Rehabilitation Programs

University of Wisconsin-Stout
College of Human Development
Stout Vocational Rehabilitation Institute
Menomonie, WI 54751
(715) 232-1219
http://www.chd.uwstout.edu/svri/rtc.html

Research and Training Center on Improving the Functioning of Families Who Have Members With Disabilities

University of Kansas
Beach Center on Families and Disability
3111 Haworth Hall
Lawrence, KS 66045
(913) 864-7600
http://www.lsi.ukans.edu/beach/beachhp.htm

Research and Training Center on Independent Living for Underserved Populations

University of Kansas
4089 Dole Building
Lawrence, KS 66045
(913) 864-0575
http://www.lsi.ukans.edu/rtcil/rtcbroc.htm

Research and Training Center on Rural Rehabilitation Services

University of Montana
Rural Institute on Disabilities
52 Corbin Hall
Missoula, MT 59812
(406) 243-5467
http://ruralinstitute.umt.edu/

Other General Disability Resources

Access/Abilities

P.O. Box 458
Mill Valley, CA 94942
(415) 388-3250

The Accreditation Council

Suite 406
100 West Road
Towson, MD 21204-2331
(410) 583-0060
(410) 583-0063 (fax)
http://www.thecouncil.org

This organization works to promote and measure quality services for people with disabilities and performs accreditation reviews for agencies that work with people with disabilities.

American Association of People With Disabilities

Suite 330
1819 H Street, NW
Washington, DC 20006
(800) 840-8844 (voice)
(202) 457-0473 (fax)
http://www.aapd.com

American Association of Retired Persons Disability Initiative

601 E Street, NW
Washington, DC 20049
(800) 424-3410 (voice)
http://www.aarp.org

American Medical Rehabilitation Providers Association (AMRPA)

3rd floor
1606 20th Street, NW
Washington, DC 20009
(888) 346-4624
(202) 833-9168 (fax)
http://amrpa.firminc.com

Association on Higher Education and Disability

P.O. Box 21192
Columbus, OH 43221-0192
(614) 488-4972 (voice)
(614) 488-1174 (fax)
ahead@postbox.acs.ohio-state.edu
http://www.ahead.org

This organization is comprised of most student disability offices in higher education. It can assist with identifying disability services at nearby community colleges and universities.

Centers for Independent Living (CILs)

Centers for Independent Living is a national network of more than 200 community-based service and advocacy programs run by people with disabilities. If you are unable to find a Center for Independent Living in your phone book, contact any of the following for assistance in locating one near you:

- Your State vocational rehabilitation agency
- National Council on Independent Living
  Suite 209
  1916 Wilson Boulevard
  Arlington, VA 22201
  (703) 525-3406 (voice)
  (703) 525-4153 (TDD)
  (703) 525-3409 (fax)
  ncil@tsbbsS02.tnet.com
- Independent Living Research Utilization Center
  Suite 100
  2323 South Shepherd
  Houston, TX 77019
  (713) 520-0232 (voice)
  (713) 520-5136 (TDD)
  (713) 520-5785 (fax)
  http://www.bcm.tmc.edu/ilru

Consortium for Citizens With Disabilities

Suite 1212
1730 K Street, NW
Washington, DC 20006
(202) 785-3388 (voice)
(202) 467-4179 (fax)
http://www.radix.net/~ccd/

Health Web

Internet Resource
http:///www.ghsl.nwu.edu/healthweb/

Independent Living for the Handicapped

1301 Belmont Street, NW
Washington, DC 20009
(202) 797-9803

Mainstream, Inc.

Suite 830
3 Bethesda Metro Center
Bethesda, MD 20814
(301) 654-2400 (voice/TDD)
(301) 654-2403 (fax)
mainstream@aol.com

National Alliance of the Disabled

1352 Sioux Street
Orange Park, FL 32065
http://www.naotd.org

The NAOTD is an online informational and advocacy organization working toward equal rights for people with disabilities.

National Association of Developmental Disabilities Councils

Suite 103
1234 Massachusetts Avenue, NW
Washington, DC 20005
(202) 347-1234 (voice)
(202) 347-4023 (fax)
http://www.igc.apc.org/NADDC

National Clearinghouse of Rehabilitation Training Materials

816 West 6th Street
Oklahoma State University
5202 Richmond Hill Drive
Stillwater, OK 74078-4080
(800) 223-5219 (voice)
(405) 624-0695 (fax)
http://www.nchrtm.okstate.edu

This organization is an excellent resource for training materials in disability areas.

National Easter Seal Society

Suite 1800
230 West Monroe Street
Chicago, IL 60606
(312) 726-6200 (voice)
(312) 726-4258 (TDD)
(312) 726-1494 (fax)

This organization provides technical assistance and referral to employers and individuals with disabilities on such topics as assistive technology, vocational training, and rehabilitation.

National Information Center for Children and Youth With Disabilities

8th floor
1875 Connecticut Avenue, NW
Washington, DC 20009
(202) 884-8200
(202) 884-8441 (fax)
http://www.nichcy.org

National Institute on Life Planning For Persons With Disabilities

Administrative Office
P.O. Box 5093
Twin Falls, ID 833-5093
(208) 735-8556 (voice)
(208) 735-8562 (fax)
http://www.sonic.net/nilp

National Organization on Disability

Suite 600
910 16th Street, NW
Washington, DC 20006
(202) 293-5960
(202) 293-7999 (fax)
http://www.nod.org

National Rehabilitation Information Center

Suite 935
8455 Colesville Road
Silver Spring, MD 20910
(800) 346-2742
(301) 495-5626 (TTD)
(301) 587-1967 (fax)
http://www.naric.com/naric/

Rehabilitation Accreditation Commission

4891 East Grand Road
Tucson, AZ 85712
(520) 325-1044 (voice/TDD)
(520) 318-1129 (fax)

The Rehabilitation Accreditation Commission promotes quality services for people with disabilities by establishing and using standards of quality for such services.

Rehabilitation Institute of Chicago

345 East Superior Street
Chicago, IL 60611
(312) 908-6066 (voice)
webmaster@rehabchicago.org
http://www.rehabchicago.org

Society for the Advancement of Travel for the Handicapped

Suite 610
347 Fifth Avenue
New York, NY 10016
(212) 447-7284
sathtravel@aol.com

World Institute on Disability

Suite 100
510 16th Street
Oakland, CA 94612-1500
(510) 763-4100 (voice)
(510) 208-9496 (TTD)
(510) 763-4109 (fax)
http://www.wid.org

Disability-Specific Service Resources

American Deafness and Rehabilitation Association (ADARA)

P.O. Box 6956
San Mateo, CA 94403
(650) 372-0620 (voice/TTD)
(650) 372-0661 (fax)
ADARAorg@aol.com

The ADARA is the largest national organization for professionals who work with persons who are deaf and hard of hearing. It provides information and referral, and networking and holds biennial conferences in topics related to substance use disorders, mental health, vocation rehabilitation, job coaching, education, and interpreting.

American Foundation for the Blind

Suite 300
11 Penn Plaza
New York, NY 10001
(800) 232-5463 (voice)
(212) 620-2158 (TDD)
(212) 727-7418 (fax)
(800) 829-0500 (product information)
http://www.afb.org/afb

This organization provides information and referral on adaptive and assistive technology for people who are blind or visually impaired.

American Printing House for the Blind

1839 Frankfurt Avenue
Louisville, KY 40206
(502) 895-2405 (voice)
(502) 899-2274 (fax)
(800) 223-1839 (Customer Service)

This organization provides Braille and large print books (including textbooks), computer voice synthesis hardware and software, computer-related materials on disk, and instructional aids.

Association of Late Deafened Adults, Inc.

Suite 274
10310 Main Street
Fairfax, VA 22030
(404) 289-1596 (TTD)
(404) 284-6862 (fax)
http://www.alda.org

The Arc (formerly Association for Retarded Citizens)

Suite 300
500 East Border Street
Arlington, TX 76010
(817) 261-6003 (voice)
(817) 277-0553 (TDD)
(817) 277-3491 (fax)
http://thearc.org/

The Arc aids the employment of people with mental retardation or developmental disability and publishes resource materials.

Brain Injury Association

105 North Alfred Street
Alexandria, VA 22314
(703) 236-6000 (voice)
(703) 236-6001 (fax)

Children and Adults With ADD

Suite 101
499 Northwest 10th Avenue
Plantation, FL 33317
(800) 233-4050
(954) 587-4599 (fax)

Learning Disabilities Association of America

4156 Library Road
Pittsburgh, PA 15234-1349
(412) 341-1515
(412) 344-0224 (fax)
http://www.ldanatl.org/

The Learning Disabilities Association of America is a national, nonprofit, volunteer organization dedicated to enhancing the quality of life for all people with learning disorders and their families. It is an advocacy organization that conducts education, research, and service.

National Association of the Deaf

814 Thayer Avenue
Silver Spring, MD 20910-4500
(301) 587-1788 (voice)
(301) 587-1789 (TTD)
(301) 587-1791 (fax)
http://www.nad.org

The National Association of the Deaf provides information and referral on deafness and accommodations for people who are deaf. It has local chapters in each State.

National Center for Learning Disabilities, Inc.

Suite 1401
381 Park Avenue South
New York, NY 10016
(212) 545-7510
(888) 575-7373
http://www.ncld.org/

National Information Center on Deafness

Galludet University
800 Florida Avenue, NE
Washington, DC 20002-3695
202-651-5051 (voice)
202-651-5054 (fax)
http://www.galludet.edu/~nicd

National Organization for Rare Disorders

P.O. Box 8923
New Fairfield, CT 06812-8923
(203) 246-6518 (voice)
(800) 999-6673 (voice)
(203) 746-6481 (fax)
http://www.pcnet.com/~orphan

A disease is considered rare if it affects fewer than 200,000 people in the United States; over 5,000 different disorders fall into this category. The NORD provides information and referrals for people with these lesser known diseases.

National Spinal Cord Injury Hotline

Kernan Hospital
2200 Kernan Drive
Baltimore, MD 21207
(800) 526-3456

Paralyzed Veterans of America

801 18th Street, NW
Washington, D.C. 20006
(202) 872-1300
http://www.pva.org/

Rehabilitation Research and Training Center on Severe Traumatic Brain Injury

1314 West Main Street
Richmond, VA 23284-2011
(804) 828-1851 (voice)

Stroke Clubs International

805 12th Street
Galveston, TX 77550
(409) 762-1022

Substance and Alcohol Intervention Services for the Deaf (SAISD)

Rochester Institute of Technology
National Technical Institute for the Deaf
115 Lomb Memorial Drive
Rochester, NY 14623-5608
(716) 475-4978 (voice/TDD)
http://www.rit.edu/sa/coun/saisd

This center publishes the *National Directory of Prevention and Treatment Programs Accessible to the Deaf*, a comprehensive directory of substance use disorder programs for people who are deaf. The 1998 edition is available electronically on SAISD's website. Printed copies of the 1995 directory can be obtained through the Rochester Institute of Technology's bookstore at (716) 475-2501.

The University of California Center On Deafness (UCCD)

Suite 10
3333 California Street
San Francisco, CA 94143-1208
(415) 476-4980 (voice)
(415) 476-7600 (TDD)

The UCCD is a research and training center focusing on deafness and mental health. They have a variety of materials, including training videos for substance use disorder treatment providers entitled "Meeting the Challenge: Working with Deaf People in Recovery," and "I Can: Stories of Deaf and Hard of Hearing People in Recovery."

Appendix C
How To Refer to People With Disabilities

The terms in the following list are the preferred words used to portray people with disabilities in a positive manner. This list is adapted from *Guidelines for Reporting and Writing about People with Disabilities* from the Research and Training Center on Independent Living (Research and Training Center on Independent Living, 1996). With a few modifications the text is the same as in the *Guidelines*.

AIDS. Acquired immunodeficiency syndrome, an infectious disease resulting in the loss of the body's immune system to ward off infections. The disease is caused by the human immunodeficiency virus (HIV). A person can test positive for HIV without displaying the symptoms of any illnesses, which usually develop up to 10 years later. Preferred: *people living with HIV, people with AIDS*, or *living with AIDS*.

Adventitious disability. A disability acquired after birth. The time of onset of a disability may result in or be affected by a substance use disorder.

Blind. A condition in which a person has a loss of vision for ordinary life purposes. *Visually impaired* is the generic term used by some individuals to refer to all degrees of vision loss. Use *boy who is blind, girl who is visually impaired*, or *man who has low vision*.

Brain injury. A condition where there is long-term or temporary disruption in brain function resulting from injury to the brain. Difficulties with the cognitive, physical, emotional, or social functioning may occur. Use *person with a brain injury, woman who has sustained brain injury*, or *boy with an acquired brain injury*. It is also referred to as traumatic brain injury.

Congenital disability. A disability that has existed since birth but is not necessarily hereditary. The term birth defect is inappropriate.

Deaf. A profound degree of hearing loss that prevents understanding speech aurally. Hard of hearing refers to mild and moderate hearing loss that may or may not be corrected with amplification. The Deaf Community is a group of people with shared experiences and values, for whom American Sign Language is often a first language and the language of choice.

Developmental disability. Any mental or physical disability starting before the age of 22 and continuing indefinitely. It limits one or more major life activities such as self-care, language, learning, mobility, self-direction, independent living, and economic self-sufficiency. This category includes individuals with mental retardation, cerebral

palsy, autism, epilepsy (and other seizure disorders), sensory impairments, congenital disabilities, traumatic injuries, and conditions caused by disease (polio, muscular dystrophy, etc.), and it may be the result of multiple disabilities. People often use this terminology to refer to a person with mental retardation.

Disfigurement. Physical changes caused by burn, trauma, disease, or congenital problems.

Down Syndrome. A chromosome disorder which usually causes a delay in physical, intellectual, and language development and often results in mental retardation. *Mongol* or *mongoloid* are unacceptable terms.

Handicap. A condition or barrier imposed by society, the environment, or by one's own self. *Handicap* is synonymous with *barrier* and not a synonym for disability. Some individuals prefer *inaccessible* or *not accessible* to describe social and environmental barriers. Handicap can be used when citing laws and situations, but should not be used to describe a disability. Do not refer to people with disabilities as *the handicapped* or *handicapped people*. Say, *the building is not accessible for a wheelchair-user. The stairs are a handicap for her.*

Learning disability. A permanent condition that affects the way individuals with average or above-average intelligence take in, retain, and express information. Some groups prefer *specific learning disability*, because it emphasizes that only certain learning processes are affected. Do not say *slow learner, retarded*, etc. Use *person with a learning disability.*

Mental disability. The Federal Rehabilitation Act (Section 504) lists four categories under mental disability: psychiatric disability, retardation, learning disability, or cognitive impairment.

Mental retardation. Substantial intellectual delay which requires environmental or personal supports to live independently. Mental retardation is manifested by below average intellectual functioning in two or more life areas (work, education, daily living, etc.) and is present before the age of 18. Preferred: *people with mental retardation.* Mental retardation is commonly referred to as a developmental disability.

Nondisabled. Appropriate term for people without disabilities. *Normal, able-bodied, healthy*, or *whole* are inappropriate because they imply that people who are disabled are not these things.

Psychiatric disability. Acceptable terms are *people with psychiatric disabilities, psychiatric illnesses, emotional disorders*, or *mental disabilities.* The following terms are pejorative: *crazy, maniac, lunatic, demented* and *psycho. Psychotic, schizophrenic, neurotic*, and other specific terms should be used only in proper context and should be checked carefully for medical and legal accuracy.

Seizure. An involuntary muscular contraction, a brief impairment or loss of consciousness, etc., resulting from a neurological condition such as epilepsy or from an acquired brain injury. Rather than *epileptic*, use *girl with epilepsy* or *boy with a seizure disorder.* The term *convulsion* should be used only for seizures involving contractions of the entire body. *Fit* is a pejorative term.

Small/short stature. Adults under 4'10". Use *persons of small (or short) stature.* Do not refer to people as *dwarfs* or *midgets. Dwarfism* is an accepted medical term, but it should not be used as general terminology. Some groups prefer *little people.* However, that implies a less than full, adult status in society.

Spastic. A muscle with sudden abnormal and involuntary spasm. It is not an appropriate term for describing someone with cerebral

palsy or a neurological disorder. Muscles are spastic, not people.

Speech disorder. A condition in which a person has limited or difficult speech patterns. Use *child who has a speech disorder*. For a person with no verbal speech capability, use *woman without speech*. Do not use *mute* or *dumb*.

Spinal cord injury. A condition in which there has been permanent damage to the spinal cord. *Quadriplegia* denotes substantial or total loss of function in all four extremities. *Paraplegia* refers to substantial or total loss of function in the lower part of the body only. Say *man with paraplegia, woman who is paralyzed,* or *person with a physical disability*.

Stroke. An interruption of blood to brain. Hemiplegia (paralysis on one side) may result. *Stroke survivor* is preferred over *stroke victim*.

Substance dependence. Patterns of use that result in significant impairment in at least three life areas (family, employment, health, etc.) over any 12-month period. Substance dependence is generally characterized by impaired control over consumption, preoccupation with the substance, and denial of impairment in life areas. Substance dependence may include physiological dependence (tolerance, withdrawal). Although such terms as *alcoholic* and *addict* are medically acceptable, they may be pejorative to some individuals. Acceptable terms are *people who are substance dependent* or *people who are alcohol dependent*. Individuals who are substance dependent and currently abstaining from substances are considered to be *in recovery*.

Appendix D
Alcohol and Drug Programs and The Americans With Disabilities Act

by Bill Bruckman, Victoria Thornton Bruckner, and Christine Calabrese

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The Alcohol, Drug, and Disability Technical Assistance Project

Pacific Research and Training Alliance's Alcohol and Drug and Disability Technical Assistance Project is one of ten projects funded by the California Department of Alcohol and Drug Programs (ADP) for underserved populations. The Project provides assistance statewide to programs and communities that will have long lasting impact and permanently improve the quality of alcohol and other drug services available to individuals with disabilities.

Pacific Research and Training Alliance (PRTA) was founded in 1990. PRTA promotes community-driven approaches to eliminate social barriers so that every person has the opportunity to participate fully in society. Other PRTA Projects include the Lesbian, Gay, Bisexual, and Transgender Technical Assistance Project, also funded by California ADP, and Living Out Loud, a substance abuse prevention project for at-risk girls, funded by the federal Center on Substance Abuse Prevention.

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This document is largely based upon the United States Department of Justice ADA Technical Assistance Manual, a compliance guide for generic public accommodations. Other public documents quoted in this publication are the U.S. Department of Justice ADA Handbook and ADA Title III Fact Sheet. Publications developed by the Resource Center on Substance Abuse Prevention and Disability in Washington, D.C., are also quoted herein. Individuals who contributed to the development of this publication include Nancy Ferreyra of Pacific Research and Training Alliance, David Abramson of the Alameda County Department of Behavioral Care Alcohol and Drug Division, and Guy Thomas of the Berkeley Center for Independent Living.

The requirements of the ADA are subject to various and possibly contradictory interpretations. The editors, therefore, used their reasonable professional efforts and judgments to interpret the Act and official U.S. Department of Justice technical assistance documents as they apply to alcohol and drug programs. The contents of this publication are presented with no warranty either expressed or implied, and Pacific Research and Training Alliance and the editors assume no legal responsibility for the information contained herein. Neither is liability assumed for the outcome of decisions, contracts, commitments or obligations made on the basis of this publication. All alcohol and drug program names used in this document are fictitious—any resemblance to actual alcohol and drug program names is purely coincidental.

Introduction

Who This Publication Is For and Why It Has Been Written

This guide is written for owners, administrators, and staff of private alcohol and drug treatment programs. Private alcohol and drug treatment programs are any programs which are not directly operated by government agencies (i.e. ADP, county or city governments). They include both non-profit and for-profit programs. They also include programs that contract and receive funds from ADP or local governments.

The purpose of this manual is to help you understand the process of coming into compliance with The Americans With Disabilities Act so that your program can become accessible to persons with disabilities.

What Is the ADA?

The Americans With Disabilities Act of 1990 is the first federal law initiated and championed by persons with disabilities. Unlike prior laws and regulations, the ADA puts the onus of accommodation on society rather than the individual with a disability.

The ADA guarantees equal opportunity for individuals with disabilities in public and private sector services and in employment. It is a comprehensive anti-discrimination law which extends to virtually all sectors of society and every aspect of daily living. The ADA is a federal civil rights act which provides the same basic civil rights protections to persons with disabilities as afforded all other Americans.

The ADA is organized into five titles.

- **Title I: Employment**—Employers with 15 or more employees must ensure that their employment practices do not discriminate against qualified people with disabilities. (In California, this applies to employers who have 5 or more employees.) Title I provides protection for job applicants and employees during all phases of employment, including the application process, interviewing, hiring, employment itself, and discharge from employment. Employers must also reasonably accommodate the disabilities of qualified applicants and employees, unless an undue hardship would result.
- **Title II: State and local government services**—Requires that public programs and services be made accessible to persons with disabilities. Mandates nondiscrimination on the basis of disability in policy, practice and procedure. Prescribes a self-evaluation process, and requires that architectural and communications barriers be removed to the extent required to provide full access to program services.
- **Title III: Public accommodations**—Title III requires places of public accommodation to be accessible to, and usable by, people with disabilities. Places of public accommodation are all private businesses and privately owned and operated programs that offer goods and services to the general public. Title III entities must not discriminate by excluding people with disabilities, treating them separately, or requiring them to participate in separate programs. Reasonable modifications must be made to policies, practices, and procedures so that people with disabilities may participate. Auxiliary aids and services that ensure effective communication with people with disabilities must also be provided so long as they do not create an undue burden or fundamentally alter the services that the program offers.
- New construction must be barrier free. In existing buildings, architectural barriers to disability access must be removed when it is readily achievable. "Readily achievable" means "easily accomplishable and able to be carried out without much difficulty or expense." Programs must review possible readily achievable barrier removal on an

ongoing basis, typically annually or with each new program budget.

- **Title IV: Telecommunications**—Title IV has mandated the establishment of a national network of telecommunication relay services that is accessible to people who have hearing and speech disabilities. It also requires captioning of all federally funded television public service announcements.
- **Title V: Nonretaliation, and other provisions**—Title V explicitly prohibits retaliation against people exercising their rights under the ADA. It sets forth specific responsibilities for the adoption of enforcement regulations by federal agencies. It also includes a number of miscellaneous provisions.

The ADA includes a set of architectural standards called the *Americans With Disabilities Act Accessibility Guidelines* (ADAAG). All Title II and Title III entities must comply with ADAAG requirements for new construction and alteration building projects. In California, public and private building projects must also comply with state accessibility regulations (Title 24). Title 24 has recently been revised to incorporate specifications found in the ADAAG. The Equal Employment Opportunity Commission and the U.S. Department of Justice have been designated as the lead ADA enforcement agencies. The Architectural and Transportation Barriers Compliance Board develops accessibility guidelines (architectural standards) for enforcement of the Act.

Who Is an Individual With a Disability?

The ADA has established the following definition of disability:

> An individual with a disability is a person who has a physical or mental impairment that substantially limits one or more "major life activities," has a record of such an impairment, or is regarded as having such an impairment.[1]

Major life activities are essential functions such as personal care tasks, manual tasks, walking, seeing, hearing, speaking, breathing, thinking, learning, and working.

In 1990, 43 million persons living in the United States were counted as eligible for protection under the ADA.[2] Still more Americans will become either temporarily or permanently disabled during their lifetimes and will claim their rights under the Act. It has been estimated that today, nearly 17 percent of the populace of California has a disability as defined by the ADA.

Of special importance to privately operated drug treatment programs is the following excerpt from the *Department of Justice ADA Title III Technical Assistance Manual:*

> Title III prohibits discrimination against drug addicts based solely on the fact that they previously illegally used controlled substances. Protected individuals include persons who have successfully completed a supervised drug rehabilitation program or have otherwise been rehabilitated successfully and who are not engaging in current illegal use of drugs. Additionally, discrimination is prohibited against an individual who is currently participating in a supervised rehabilitation program and is not engaging in current illegal use of drugs. Finally, a person who is erroneously regarded as engaging in current illegal use of drugs is protected.[3]

It should be noted, however, that drug testing is permitted under Title III and that individuals who engage in the illegal use of drugs are not protected by the ADA when an action is taken on the basis of their current illegal use of drugs. (See sections titled, "Can we refuse services to individuals currently engaging in illegal use of drugs?" and "Is drug testing permitted?" on page 130.)

What Does the ADA Require of Privately Operated Alcohol and Drug Programs?

Alcohol and drug programs operated by private agencies (whether or not they receive Federal, State, or local funding) are considered places of public accommodation under the ADA and are therefore subject to Title III requirements. The remainder of this manual discusses the requirements of Title III of the ADA in detail so that providers can gain understanding of how to comply with Title III.

The Civil Rights Division of the U.S. Department of Justice has provided the following overview of the responsibilities of Title III entities. Under the ADA, a privately operated alcohol or drug program must:

- Provide services to people with disabilities in an integrated setting, unless separate or different measures are necessary to ensure equal opportunity.
- Eliminate unnecessary eligibility standards or rules that deny individuals with disabilities an equal opportunity to enjoy the activities, benefits, and services of alcohol and drug programs.
- Make reasonable modifications in policies, practices, and procedures that deny equal access to individuals with disabilities, unless a fundamental alteration in the nature of the program would result.
- Furnish auxiliary aids when necessary to ensure effective communication, unless an undue burden or fundamental alteration would result.
- Remove architectural and structural communication barriers in existing facilities where readily achievable.
- Provide ... alternative ... [means of delivering services] when removal of barriers is not readily achievable.
- Provide equivalent transportation services and purchase accessible vehicles in certain circumstances. [If the program provides transportation to its clients, equivalent accessible transportation for clients with disabilities must be provided.]
- Maintain accessible features of facilities and equipment.
- Design and construct new facilities and, when undertaking alterations, alter existing facilities in accordance with the *Americans With Disabilities Act Accessibility Guidelines* issued by the Architectural and Transportation Barriers Compliance Board and incorporated in the final Department of Justice Title III regulation.[4]

Four Steps Toward ADA Compliance:

Privately operated alcohol and drug programs must take action to overcome four fundamental groups of barriers in order to comply with ADA requirements and provide people with disabilities an equal opportunity to benefit from services. They are as follows:

1. Attitudinal barriers
2. Discriminatory policies, practices, and procedures
3. Communication barriers
4. Architectural barriers

The remainder of this booklet will elaborate upon actions to take to facilitate the removal of these four groups of barriers.

Step One: Changing Attitudes That Prevent Access to Alcohol and Drug Programs for Persons With Disabilities

An attitudinal barrier to substance abuse intervention and treatment can be defined as a way of thinking or feeling that results in limiting the potential of people with disabilities to function independently within society and to be

"treatable" and recognized as wanting help with their substance abuse problems.[5]

How Important Is Disability Related Training for Alcohol and Drug Staff?

There are many unique issues in the provision of alcohol and drug rehabilitation services to persons with disabilities.

In order to make ADA compliance efforts truly successful, alcohol and drug program staff must have the skills and the willingness to respond to the needs of clients with disabilities. Staff training is key to overcoming attitudinal barriers that prevent people with disabilities from receiving equally effective alcohol and drug treatment services.

Disability-awareness training should include efforts to ensure that staff members: 1) overcome their fears and stereotyping of people with disabilities; 2) learn the rights of people with disabilities and the responsibilities of alcohol and drug programs under the ADA; and 3) develop skills and resources to provide equally effective services to people with disabilities.

People with disabilities who are familiar with the ADA and alcohol and drug programs can provide the best initial training for alcohol and drug program staff. Pacific Research and Training Alliance (PRTA) is one organization that provides such specialized services. Your local independent living center should also be an excellent resource for meeting persons with disabilities who can provide pertinent training and technical assistance. Ongoing training of new staff can include the use of videos. "J.R.'s Story" is a video that elaborates on many of the unique issues faced by a client with a disability who eventually seeks chemical dependency treatment. Contact PRTA regarding training services, for a list of independent living centers in California, and for information on how to borrow or purchase this and other videos.

Negative myths about disability tend to lessen opportunities for people with and without disabilities to have social contact with each other. It is crucial that providers who attend disability awareness training have the opportunity to meet and ask questions of people with a wide variety of disabilities, especially people with disabilities who are in recovery. Panel discussions often provide the best opportunity for this dialogue and serve as a possible springboard for further contact and cooperation.

High quality disability awareness training should be led by facilitators who have the skills to create an environment in which people feel free to discuss the fears that they have and the stereotypes that they still may hold. Pacific Research and Training Alliance can supply an appropriately trained consultant with extensive experience in delivering disability awareness training to audiences of alcohol and other drug (AOD) providers and staff.

In addition, fact sheets about issues related to substance use and abuse by people with various disabilities are available from the Resource Center for Substance Abuse Prevention and Disability in Washington, D.C. These fact sheets compare myths and facts about people with many types of disabilities and discuss strategies for overcoming attitudinal barriers that prevent people with disabilities from accessing AOD services. They also discuss some of the typical reasonable accommodations for many disabilities. Pacific Research and Training Alliance (PRTA) can furnish information about how to order these fact sheets. PRTA has also developed many other educational materials and curricula on the subject of disability and chemical dependency.

All of these written materials are an invaluable addition to any disability awareness training. They include many references and resources for further reading that is important for both program administrators and staff.

How Serious Is the Problem of AOD Abuse Among People With Disabilities?

Persons with disabilities currently seek alcohol and drug services in small numbers, yet they are at a higher risk for alcohol and drug addiction. Studies have shown that alcohol and drug abuse rates for people with disabilities may range from 15 to 30 percent of all persons with disabilities; rates for people with certain disabilities such as spinal cord and head injury exceed 50 percent.[6]

People without disabilities commonly do not think of people with disabilities as having chemical dependency problems. However, these problems are widespread, and if ignored, they worsen.

There are many reasons why people with disabilities do not avail themselves of alcohol and drug treatment services. These range from individual difficulties such as lack of social skills or chronic pain to societal problems such as lack of targeted outreach, lack of transportation, and inaccessible facilities. Many of these problems can be resolved during the alcohol and drug program's initial ADA compliance effort. Other issues can be addressed by working closely with each individual with a disability and with disability advocacy organizations.

Do We Have To Comply With the ADA Even If We Have Never Served a Person Who Is Disabled?

The intention of the ADA is to bring people with disabilities into the mainstream of American society. The ADA requires that individual agencies make their programs accessible and it is the clear responsibility of alcohol and drug programs to seek out clients with disabilities.

The following actions have proved effective in creating a client base of people with disabilities:

1. Institute an ongoing campaign to publicize your program to people with disabilities. Send disability-specific program information to local advocacy agencies for persons with disabilities, including the Department of Rehabilitation, campus disabled student services offices, independent living centers, and rehabilitation hospitals and clinics. Also include advocacy groups for parents of children with disabilities, and advocacy organizations for people with specific disabilities, such as arthritis, cerebral palsy, multiple sclerosis, muscular dystrophy, and vision and hearing disabilities. Don't forget your local mental health association, and local veterans and seniors groups. Your local United Way may be able to help you to locate these organizations. Wherever possible, develop outreach materials in formats which are accessible to people with disabilities, such as in large print, on audiocassette, or on computer disk. Also arrange for any outreach videos to be captioned for people with hearing impairments.
2. Establish links with organizations in your community that provide advocacy and services to people with disabilities, such as independent living centers. Invite their representatives to speak at staff meetings and send your staff to speak at their events.
3. Actively seek qualified persons with disabilities when searching for advisory board members.
4. Actively seek qualified persons with disabilities when hiring new staff members.
5. Develop prevention and treatment services that target specific populations of persons with disabilities. Some possibilities include the following:

   a. Providing some initial information or counseling services in disability-specific settings.

      EXAMPLE 1: Arrange to give a talk or facilitate a rap group on alcohol and drug issues at an independent living center or a rehabilitation hospital.

EXAMPLE 2: Offer drop-in peer counseling on alcohol and drug issues at an accessible community center. Air radio public service announcements about this service and send written announcements about this peer counseling to independent living centers and other disability advocacy groups.

b. Working with local Alcoholics Anonymous and Narcotics Anonymous groups to make meetings accessible.

EXAMPLE 1: Help locate resources to fund sign language interpreting at a local AA meeting.

EXAMPLE 2: Assist a local NA group to find an accessible meeting site.

Step Two: Revising Policies, Practices, and Procedures To Ensure Access

Access for people with disabilities is often thought of in terms of physical access to the built environment. Most people understand the need for ramps, curb cuts, and parking spaces for people with disabilities. What many do not consider are the nonphysical barriers to people with disabilities—policies, practices, and procedures that discriminate or tend to discriminate on the basis of disability. We can't see these "administrative barriers" but they have as much impact on people with disabilities as physical ones.

The ADA sets forth a substantial number of requirements to protect people with disabilities from administrative barriers. It is necessary for alcohol and drug programs to review existing policies, practices, and procedures and adopt new ones in order to avoid discrimination and ensure compliance with ADA Title III requirements. The administrative review should be performed by the program director or another individual who is thoroughly familiar with the program and has the authority to effect policy changes.

The following section is intended to answer questions that you may have about specific policies, practices, and procedures relevant to alcohol and drug program operation.

Admitting People With Disabilities Into Your Program

Discriminating against people with disabilities often occurs during first contact. Therefore, an important first step is to review admissions policies, practices, and procedures. Drug and alcohol program admissions includes recruitment, referral, screening, and intake of clients with disabilities—everything that occurs prior to receipt of services or participation in the program.

May We Refuse To Admit People With Disabilities?

Programs may not refuse to admit people solely based upon disability. Blanket policies, practices, and procedures that prohibit the participation of people with disabilities are discriminatory.

May We Decide To Restrict the Participation of People With Certain Disabilities?

No. Alcohol and drug programs should not presume that an individual or class of individuals with a disability can or cannot participate in any aspect of a program. An important step in ensuring nondiscrimination on the basis of disability is to establish procedures by which each individual is evaluated based upon his or her unique needs and abilities.

Even if architectural or communications barriers seemingly prevent program access for people with certain disabilities, the program must give each individual with a disability an opportunity to determine for him- or herself

whether he or she can function within the program's constraints.

> EXAMPLE: A program, named Awake, has no funds to hire staff with special training in communicating with people who have had strokes. The program cannot, however, refuse to admit people with severe speech impairments caused by a stroke based upon this constraint. An individual with a severe speech impairment caused by a stroke must be apprised of the program's limitations, and other programs seemingly more suited to his or her needs may be suggested, but the individual can still opt to participate in the Awake program.

Can We Limit the Number or Proportion of People With Disabilities Admitted to Our Program?

No. Quotas are prohibited under the ADA.

> EXAMPLE: A program cannot limit the number of deaf persons that it serves in a given year based upon the desire to limit sign language interpreting costs.

If architectural, financial, or other constraints limit the number of people with disabilities that a program can serve at any given time, the program must make every effort to ensure that individuals with disabilities are provided with other options for services such as a referral to a comparable program. *The individual with a disability should be apprised of all options and his or her preference for placement must be given primary consideration.*

> EXAMPLE: A residential recovery program has only one wheelchair-accessible bedroom that is currently occupied. A person who uses a wheelchair but can walk short distances may opt to enter the program immediately even though the wheelchair-accessible bedroom is not available. A person who is quadriplegic may, however, require a referral to an alternate accessible program.

What If a Person's Disability Makes Him or Her Unable To Meet Our Eligibility Requirements?

Alcohol and drug programs may require that people with disabilities meet essential eligibility criteria in order to participate in programs and services, and they may refuse services to individuals with disabilities who cannot meet these admission requirements. Programs must, however, demonstrate that these requirements *are essential* and that no person with a disability is unnecessarily excluded or limited from participation in programs and services.

Essential requirements are those requirements that are fundamental to the nature of a program or activity.

> EXAMPLE 1: A program cannot require that clients present a valid driver's license in order to receive services because the ability to drive is not essential to alcohol and drug recovery. Other forms of identification, such as a social security card or birth certificate, should be accepted in lieu of a driver's license.

> EXAMPLE 2: A methadone maintenance program is approached by a blind woman who is a crack cocaine user. The woman has no history of using heroin or other opiates. The program may deny her its services because they are specifically designed for heroin users. The program should refer her to other treatment services for crack cocaine users.

The Department of Justice does not consider it discriminatory for a program with a specialty in a particular area to refer an individual with a disability to a different program if:

- The individual is seeking a service or treatment outside the referring program's area of expertise; and
- The program would make a similar referral for an individual who does not have a disability.[7] For example, a private agency

provides recovery meetings for Latino immigrants. A person who uses a wheelchair but is not a Latino immigrant asks to attend the meetings. The agency may refer the individual to another agency that provides accessible meetings.

May We Require Further Information or Documentation From Persons With Certain Disabilities?

Programs cannot require that people with certain disabilities provide information not required of other applicants. Eligibility for participation may not be determined based upon disability unless the program or service is specifically designated for people with disabilities.

EXAMPLE: A program cannot require that an applicant with HIV provide medical records or disclose health information that is not required of other applicants.

What Is "Illegal Use of Drugs"?

According to the Department of Justice, "illegal use of drugs means the use of one or more drugs, the possession or distribution of which is unlawful under the Controlled Substances Act. It does not include use of controlled substances pursuant to a valid prescription or other uses that are authorized by the Controlled Substances Act or other federal law. Alcohol is not a controlled substance, but alcoholism is a disability."[9]

What Is "Current Use"?

The Department of Justice defines current use as "the illegal use of controlled substances that occurred recently enough to justify a reasonable belief that a person's drug use is current or that continuing use is a real and ongoing problem. Therefore, a private entity should review carefully all the facts surrounding its belief that an individual is currently taking illegal drugs to ensure that its belief is a reasonable one."[10]

Can We Refuse Services to Individuals Currently Engaging in Illegal Use of Drugs?

The Department of Justice offers the following guidance in regard to the illegal use of drugs by those seeking drug rehabilitation services:

> Drug addiction is an impairment under the ADA. A public accommodation generally, however, may base a decision to withhold services or benefits in most cases on the fact that an addict is engaged in the current and illegal use of drugs.
>
> Although individuals currently using illegal drugs are not protected from discrimination, the ADA does prohibit denial of health services, or services provided in connection with drug rehabilitation, to an individual on the basis of current illegal use of drugs, if the individual is otherwise entitled to such services.
>
> Because abstention from the [illegal] use of drugs is an essential condition for participation in some drug rehabilitation programs, and may be a necessary requirement in inpatient or residential settings, a drug rehabilitation or treatment program may deny participation to individuals who use drugs [illegally] while they are in the program.[11]
>
> EXAMPLE: It would be inappropriate for a crack cocaine detoxification program to refuse to admit an individual because she is illegally using crack cocaine. A residential alcohol and drug treatment program may, however, expel an individual for illegal use of drugs in its treatment center.

Is Drug Testing Permitted Under the ADA?

Yes. The Department of Justice has indicated that, "public accommodations may utilize reasonable policies or procedures, including but not limited to drug testing, designed to ensure that an individual who formerly engaged in the illegal use of drugs is not now engaging in current illegal use of drugs."[12] It is important not to discriminate against those who

appropriately use medications. Sometimes individuals who are appropriately using prescription medications will test positive, even if they have not been using drugs illegally, because the drug test is not sensitive enough to discriminate between different types of drugs.

Can We Refuse to Serve an Individual Whose Disability Poses a Direct Threat to the Health and Safety of Others?

One of the rare instances when a program may deny participation in activities to a person based upon disability is when the individual's disability legitimately presents a direct threat to the health or safety of others that cannot be eliminated or reduced to an acceptable level by reasonable changes to policies, practices, or procedures or by the provision of auxiliary aids and services. The program must establish that the perceived threat is real and not based upon preconceptions or unwarranted fears about the individual's disability. Assessments must consider both the particular activity and the actual abilities and disabilities of the individual.

The Department of Justice gives the following guidance for direct threat assessment: The individual assessment must be based on reasonable judgment that relies on current medical evidence, or on the best available objective evidence, to determine

- The nature, duration, and severity of the risk
- The probability that a potential injury will actually occur
- Whether reasonable modifications of policies, practices, or procedures will mitigate or eliminate the risk

Such an inquiry is essential to protect individuals with disabilities from discrimination based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to legitimate concerns, such as the need to avoid exposing others to significant health and safety risks. Making this assessment will not usually require the services of a physician. Sources for medical knowledge include public health authorities, such as the U.S. Public Health Service, the Centers for Disease Control, and the National Institutes of Health, including the National Institute of Mental Health.[12]

EXAMPLE 1: A program may not refuse to admit an individual because he or she is infected with HIV. HIV is not a direct threat to the health and safety of other program participants because it cannot be transmitted through casual contact.

EXAMPLE 2: A program may refuse to admit an individual with a contagious form of tuberculosis if the program finds that it cannot reasonably provide other clients adequate protection from the disease.

EXAMPLE 3: A man with a traumatic brain injury who is often loud and aggressive may not be denied admission to a program because of staff or participants' fears that he may exhibit violent behavior. However, if he recently placed others at risk during a violent outburst, the program may place behavioral limits on his admission or participation in specific activities, as long as those limits are the same as those expected of other applicants or participants.

When Can We Ask About Disability?

Inquiries regarding disability made prior to acceptance into an alcohol or drug program are generally unnecessary and should not be made. Once a person has been accepted into the program, necessary inquiries can be made regarding special accommodations that an individual may need. Application forms, consent forms, and other documents where such inquiries are made should be reviewed and revised accordingly.

EXAMPLE 1: A residential perinatal program should not require that a woman fill out an application form that asks about additional medical conditions until she has been admitted to the program.

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EXAMPLE 2: A residential recovery program for persons who are HIV-positive may inquire as to the history of a person's alcoholism and ask for an HIV-positive test result prior to admission because having both disabilities is a prerequisite for participation.

EXAMPLE 3: During an intake interview, program staff cannot ask applicants questions about how they acquired their disabilities or why they use mobility aids such as wheelchairs.

What Questions Can We Ask About Disability?

Necessary inquiries about disability are questions asked in order to provide services, not deny them. This includes questions asked to provide program modifications, auxiliary aids and services, health care, or emergency services to the client; questions asked to assess the client's conformance with legitimate health and safety requirements, and questions asked for some other essential purpose. Unnecessary inquiries about disability include questions asked to screen out the participation of people with disabilities, to satisfy one's curiosity, or to discriminate in the provision of treatment, health care, emergency services, etc. They are in direct violation of the ADA. Alcohol and drug programs should adopt policies and procedures to ensure that written and verbal inquiries about disability are limited to necessary ones.

While alcohol and drug programs cannot require that clients disclose information about disability, they may give clients an opportunity to voluntarily provide information about disability. This is especially true if the intention is to use information about disability in order to accommodate the client.

Is Information About a Client's Disability Confidential?

Yes. Programs should have a written policy and procedure in place to ensure that records pertaining to a client's disability are kept confidential and not used in a discriminatory fashion.

To What Extent Must We Modify Our Policies, Practices or Procedures for Individuals With Disabilities?

The ADA requires that privately operated alcohol and drug programs make reasonable modifications to policies, practices, or procedures when required to ensure equal opportunity and avoid discrimination against people with disabilities. Reasonable modification means any modification that does not fundamentally alter the nature of the services provided. In this way, the burden of accommodation is placed upon the program, not the client. Clients should, however, be consulted as to the modifications they need to successfully participate in the program.

EXAMPLE 1: A residential social model treatment program which has a "drug-free" policy for its residents must modify that policy to allow for the appropriate use of prescribed medications in order to avoid discriminating against a qualified applicant who has to inject himself daily with insulin because he has diabetes. The program would also have to allow a qualified applicant with epilepsy to take appropriately prescribed antiseizure medications according to her doctor's instructions.

The barbiturate Phenobarbital has occasionally been prescribed to control seizures. If an applicant took Phenobarbital *as prescribed*, the program could not refuse to admit her for this reason. Program administrators and staff might appropriately accommodate her by modifying the program's drugfree policy *and* establishing additional security procedures so that her medication would not be misused or fall into the hands of other participants.

EXAMPLE 2: A methadone treatment facility requires that clients pass a urine screening just prior to receipt of medication. Clients must urinate in the presence of program staff to ensure the validity of the test. It would not be reasonable for the program to waive the drug

screening requirement for a person with a disability even if that person's disability prevented him from providing urine samples on demand. Alternative methods of screening would need to be provided as a reasonable accommodation.

When Is It Appropriate To Place Persons With Disabilities in Separate Programs Designed Especially for Them?

The primary emphasis of alcohol and drug service providers in serving persons with disabilities must be integration into regular programs. However, the ADA does not prohibit the establishment of target programs to serve communities of persons with disabilities, such as a residential treatment facility for persons who are deaf.

Nevertheless, individuals with disabilities cannot be excluded from regular programs or required to accept special services or benefits simply because special or target programs are available.[13]

EXAMPLE: A county has established a special residential facility for persons with traumatic brain injuries and alcohol or drug addictions. The county may offer this separate program in order to meet the unique cognitive and environmental needs of persons with traumatic brain injuries in recovery. The county cannot, however, require that persons with traumatic brain injuries participate in this special program or refuse to admit them to regular programs because of their disability.

Can Persons With Disabilities Refuse Special Services and Choose Instead To Participate in Regular Programs?

Yes. Persons with disabilities are entitled to participate in regular programs whether or not alcohol and drug program personnel believe that they can benefit from regular services. The existence of special programs does not relieve alcohol and drug programs of their obligation to provide reasonable modifications and auxiliary aids and services to individuals choosing to participate in the regular program.[14]

EXAMPLE: A residential facility called Transitions is located in a rural setting and residents perform farm labor as part of the treatment program. A wheelchair user named Joe applies to Transitions. Program staff advise him that a rigorous physical routine is a fundamental part of the Transitions program. They suggest an alternate program that offers special services for persons with mobility disabilities.

Joe chooses to join the Transitions program despite the availability of a special program suited to his disability. He believes that he can negotiate the terrain of the Transitions facility and do some of the required physical labor with limited program modifications.

Transitions may limit the extent of modifications provided to Joe because of the availability of an appropriate separate program, but they cannot refuse to admit Joe. Transitions must still reasonably accommodate Joe, including providing transportation for Joe if transportation is provided for other clients, but they need not make extraordinary modifications, such as the purchase of costly specialized farming equipment. They may also modify Joe's chore schedule, with input from Joe regarding which chores he is able to perform.

Is Our Program Required To Cover the Cost of Personal Equipment and Attendant Services?

While a public accommodation is required to provide auxiliary aids for effective communications (such as telecommunications devices for deaf persons) and reasonable personal assistance to persons with disabilities (such as help with filling out an application form), it is not required to provide equipment or services of a personal nature such as wheelchairs, prescription eyeglasses, hearing aids, or assistance in eating, toileting, and dressing.[15]

Can We Charge People With Disabilities for the Extra Costs of Providing Services to Them?

No. ADA compliance measures may result in an additional cost for serving clients with disabilities. Alcohol and drug programs may raise the fee for all clients but they may not place a surcharge on particular individuals with disabilities or groups of individuals with disabilities to cover these expenses.

> EXAMPLES: A methadone program is located on the second floor of an older four-story building that does not have an elevator. Because the director has determined that providing physical access to the program for those unable to climb stairs would not be readily achievable, she has chosen to provide home services as a readily achievable alternative to barrier removal. A medical technician will visit clients' homes to perform urine tests and give injections, and counselors will provide services to clients by phone. The program may not charge individuals who receive home care for the additional cost of providing services to them.[16]

Can We Prohibit Smoking?

Yes. The Department of Justice has indicated that public accommodations such as alcohol and drug programs "may prohibit smoking, or may impose restrictions on smoking, at their facilities."[17]

Must We Allow the Use of Service Animals in Our Facility?

Yes. Alcohol and drug programs must allow a service animal (such as a guide, hearing or companion dog) to accompany a person with a disability for all services except when doing so would fundamentally alter the particular activity or jeopardize the safe operation of the program. (See section titled "Limitations and Alternatives" below.)

It is the responsibility of the animal's owner to feed, walk, and care for the service animal in any other way.

> EXAMPLE: An individual who is blind wishes to be accompanied by his guide dog to an alcohol and drug program orientation session. The alcohol and drug program must permit the guide dog to accompany its owner in all areas of the facility open to other clients, and may not insist that the dog be separated from him at any time. Furthermore, the client may not be charged a deposit as a condition for permitting the service animal into the program's facility.[18]

The ADA Protects People With Disabilities and Their Allies From Retaliation or Coercion

Alcohol and drug programs may not take any retaliatory action against persons who exercise their rights under the ADA or individuals who assist others in exercising their rights. This prohibits the suspension or termination of employees for advising persons with disabilities of their right to reasonable modifications and auxiliary aids and services in the program.[19]

Step Three: Understanding Is Everything—Overcoming Communications Barriers

The ADA requires alcohol and drug programs to ensure that communications with people with disabilities are as effective as communications with others. Communications conducted by alcohol and drug programs include outreach, education, prevention efforts, intake interviews, group meetings, counseling sessions, telephone and mail communications, and provision of medical services. Communication barrier removal is especially important for people who are deaf or have hearing, speech, visual, and learning disabilities.

What Are Auxiliary Aids and Services?

In many cases, ensuring effective communication entails the provision of auxiliary aids and services—a wide range of practices and equipment that allow people with disabilities to communicate and access information. The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the nature and duration of the communication and the individual person's preference and ability to use a particular aid or service.[20] The Department of Justice gives the following examples of auxiliary aids and services:

> Auxiliary aids and services for individuals who are deaf or hard of hearing include qualified interpreters, notetakers, computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons (TDDs), videotext displays, and exchange of written notes.
>
> Examples for individuals with vision impairments include qualified readers, taped texts, audio recordings, Brailled materials, large print materials, and assistance in locating items.
>
> Examples for individuals with speech impairments include TDDs, computer terminals, speech synthesizers, and communication boards.[21]

What Range of Auxiliary Aids and Services Must We Provide?

Public accommodations such as alcohol and drug programs should be prepared to provide the widest variety of auxiliary aids and services possible to people with disabilities. The ADA suggests that individuals with disabilities be given the opportunity to request the auxiliary aids and services of their choice and that primary consideration be given to the choice expressed by the individual.

It is important to consult with the individual to determine the most appropriate auxiliary aid or service, because the individual with a disability is most familiar with his or her disability and is in the best position to determine what type of aid or service will be effective. For example, some individuals who were deaf at birth or who lost their hearing before acquiring language use sign language as their primary form of communication. They may be uncomfortable or not proficient with written English. This makes use of a notepad an ineffective method of communication with them. Some individuals who lose their hearing later in life, however, may not be skilled in sign language and can communicate most effectively through writing.

The Department of Justice states that, while consultation is strongly encouraged, the final decision as to what measures to take to ensure effective communication rests in the hands of the alcohol and drug program, provided that the method chosen results in effective communication.[22]

When Must We Provide Auxiliary Aids and Services?

If needed to ensure effective communication, auxiliary aids and services must be provided at all phases of a client's participation in an AOD program. This would include application, intake, counseling, group meetings and all social activities. It would extend to followup contact after the client has left the program, if this service is usually provided.

Limitations and Alternatives (Claiming Fundamental Alteration Or Undue Burden)

The ADA does not require privately operated alcohol and drug programs to provide any auxiliary aids and services that would

fundamentally alter the nature of the programs and services they offer or result in an undue financial burden.

What Is a Fundamental Alteration?

A fundamental alteration as defined by the Department of Justice is "a modification that is so significant that it alters the essential nature of the goods, services, facilities, privileges, advantages, or accommodations offered."[23]

What Is an Undue Burden?

Undue burden is defined as "significant difficulty or expense." The Department of Justice advises programs to consider the following factors in determining whether an action would result in an undue burden:

- The nature and cost of the action;
- The overall financial resources of the site or sites involved; the number of persons employed at the site; the effect on expenses and resources; legitimate safety requirements necessary for safe operation, including crime prevention measures; or any other impact of the action on the operation of the site;
- The geographic separateness, and the administrative or fiscal relationship of the site or sites in question to any parent corporation or entity;
- If applicable, the overall financial resources of any parent corporation or entity; the overall size of the parent corporation or entity with respect to the number of its employees; the number, type, and location of its facilities; and
- If applicable, the type of operation or operations of any parent corporation or entity, including the composition, structure, and functions of the workforce of the parent corporation or entity.[24]

Any program that cannot provide an accommodation because of fundamental alteration or undue burden concerns should make every effort to provide an equally effective alternative accommodation. The program should carefully document the entire process and be prepared to substantiate their claim of fundamental alteration or undue burden in a court of law.

> EXAMPLE: An individual who is deaf requests that a sign language interpreter be provided at all times while he is participating in a day treatment program. The program operates on a small budget and cannot afford to hire an interpreter for frequent and extended periods of time. The program has tried and failed to find volunteer interpreters. The program determines that it would be an undue financial burden to provide professional interpreting services for all aspects of services but resolves to provide an interpreter for weekly counseling sessions and all group meetings. Furthermore, the program welcomes the client to bring a friend or relative to interpret for him at other times and makes a computer terminal available for typed communications between the deaf client and program staff.

Who Is Qualified To Provide Sign-Language Interpreting Services?

A program must ensure that any interpreter it hires or otherwise provides is qualified. There are a number of sign languages used. (The most common methods of communication are American Sign Language and signed English.) Individuals who use one form of sign language may not communicate effectively through an interpreter who uses a different one. A qualified interpreter is an interpreter who is able to sign to the individual who is deaf what is being said by the hearing person and who can voice to the hearing person what is being signed by the individual who is deaf. This communication must be conveyed effectively, accurately, and impartially through the use of any necessary specialized vocabulary, and in the type of sign language the deaf person uses.[25]

How Do We Make Telephone Communications Accessible?

If your program has frequent or extensive telephone communications with clients and members of the general public, a telecommunications device for the deaf (TDD) makes telephone communications accessible to individuals who are deaf, hard-of-hearing, or speech impaired. A TDD allows individuals to communicate over regular telephone lines through text rather than voice. Often, a continuous tone or a series of beeps will be heard when an individual calls from a TDD. This is the signal to place the phone receiver in your TDD machine and begin text communication. You may consider installing a separate telephone line for TDD calls to eliminate confusion when receiving a TDD signal over the regular telephone line. If you do provide a separate TDD phone line, that number should be listed wherever you advertise the number for regular telephone service.

In California, individuals who use a TDD may communicate with agencies without a TDD through a service called the California Relay Service, 1-800-735-2922 (voice) and 1-800-735-2929 (TDD). An operator acts as an intermediary, reading to the agency staff what the TDD caller is typing and typing to the TDD caller what the agency staff is saying. Until your program obtains a TDD, it should use the relay service to call clients who have TDDs. Program staff should be advised that some individuals will use the relay service to call even if you have a TDD. These calls should always be accepted.

What About Outgoing Calls by Clients, Patients, or Visitors?

The Department of Justice advises that "TDDs must be provided when customers, clients, patients, or participants are permitted to make outgoing calls on more than an incidental convenience basis. For example, TDDs must be made available on request ... where in-room phone service is provided."[26] If calls come to the front desk before they are transferred to clients' rooms, the front desk should also be equipped with a TDD so that clients using TDDs in their rooms have the same access to in-house services as other clients.

How Do We Make Print, Audiocassette, Videos, and Other Materials Accessible?

Communication barriers also appear when programs attempt to send outreach materials to people with disabilities. If advertising, prevention, or other materials are not available in a format that is appropriate for a person with a disability, then programs should make that material available in an appropriate alternative format. Alternative formats include but are not limited to the following:

- Print materials may be made available to blind or visually impaired individuals in audiotape, large print, computer disk, Braille or raised text format.
- Print materials may be made available to people with limited upper body use in computer disk format.
- Videotapes may be made available to deaf or hard-of-hearing individuals in captioned format (with subtitles).
- Audiotapes may be made available to deaf or hard-of-hearing individuals in print format.

How Can We Make Advertisements Accessible?

If your program advertises its services, then such advertisements should be made in a sufficient variety of formats to ensure access to people with disabilities. For example, radio advertisements are not accessible to the deaf and newspaper advertisements are not readily accessible to the blind. Only with a combination of the two would both communities be reached. In addition, programs should make an effort to contact those media

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resources that are frequently used by the disability community.

Designing and Selecting Outreach, Prevention, and Other Materials

Programs should include the following in all outreach, prevention, and other materials that they produce:

- A statement of the program's responsibilities under the ADA and its commitment to provide effective communication to people with disabilities.
- A description of the accommodations and resources that the program has available for people with disabilities.

No new or existing outreach, prevention, or other material *produced* by the program should contain any discriminatory language or representation of people with disabilities. Programs should also take steps to ensure that no material produced by others, but *distributed* by the program, contains any discriminatory language or representation of people with disabilities.

It may be an unwieldy task for a program to review each of the materials that it currently distributes. As an alternative, programs may choose to establish a procedure by which persons can file a complaint if they find any material to be discriminatory against people with disabilities. A complaint review procedure should be established. Remedies may include discontinuing use of the material or removing the discriminatory portion of the material.

When selecting or designing new materials, PRTA recommends that programs should make an effort to find or produce materials that contain positive representations of people with disabilities. In addition, an appropriate number of materials should address issues specific to disability. For example, you may include a video that addresses the issue of deafness and alcohol use in your video library. PRTA suggests that an "appropriate number" of materials should address disability-related issues. Since over 15 percent of California's population are people with disabilities we recommend that at least 15 percent of your program's materials address the needs of this population.

How Do We Make Open Meetings And Other Public Events Accessible?

The following are minimum guidelines for holding an accessible meeting or other public event:

- Make invitations, flyers, and other announcements available in alternative formats upon request. Conduct outreach to persons with known disabilities in an appropriate format.
- Include clip-and-return form and phone numbers on announcements that allow persons with disabilities to contact your program in advance and request accommodations such as large-print handouts or sign-language interpreter services.
- Hold public events at a wheelchair-accessible location. At a minimum, these sites should have wheelchair-accessible parking, entrances, paths of travel, seating, toilet facilities, and public phones.
- If possible, secure a sign language interpreter for the event. Otherwise, provide notice in your advertisements that a sign language interpreter will be available if requested 72 hours in advance.
- If possible, make written handout materials readily available in the following common alternative formats: large print, computer disk, and audiocassette.
- Place refreshments and handout materials in an accessible location.

Step Four: It Doesn't Have To Cost Much!—Physical Access Can Be Readily Achieved

Under the ADA, privately operated alcohol and drug programs should remove architectural (or physical) barriers to program areas in existing facilities where it is *readily achievable* to do so. Readily achievable is defined by the Department of Justice as "easily accomplishable and able to be carried out without much difficulty or expense." New construction and alteration requirements are much more stringent than the readily achievable barrier removal standard for existing facilities. When undertaking a new construction or alteration project, privately operated alcohol and drug programs in California must comply with the Americans With Disabilities Act Accessibility Guidelines (ADAAG) and state accessibility regulations (Title 24.)

Title III allows that barriers be removed slowly, over time, as it becomes readily achievable to do so. According to Title III, programs should have removed all those barriers they readily could by January 26, 1992. Over time, programs are obligated to take stock of barriers that remain and to evaluate what resources they have, so that they can determine which additional barriers can be removed.

Because the California Department of Alcohol and Drug Programs (DADP) and each county has its own obligations under the ADA and the Rehabilitation Act of 1973, the state and counties may hold AOD programs they fund to a higher standard of access than readily achievable. The state and counties are likely to require that all publicly funded alcohol and drug programs with 15 or more employees achieve *programmatic access*. This means that physical barriers to programs and services must be removed whether or not it is readily achievable to do so. Agencies with several facilities may be allowed to make only one facility accessible per this higher standard *if* each facility provides essentially the same program (same modality and target population) and the facilities are located within the same general geographic area.

Programs with fewer than 15 employees may be required to refer persons with disabilities to essentially equivalent accessible programs within their service group. If no such equivalent accessible program is available, publicly funded programs with fewer than 15 employees will most likely be required to achieve programmatic access. Your county alcohol and drug program administrator or DADP ADA coordinator can help you determine what is currently required of your program.

In addition, PRTA recommends that programs should have a long-term plan to achieve programmatic access whether or not immediately required by the state.

ADAAG or California Title 24 regulations are often used as the standard to survey a facility. Once the survey is complete, a program can narrow the scope of renovation depending upon the level of access immediately required—readily achievable or programmatic access.

Programs that have not already done so should perform a survey of their facilities to identify physical barriers to programs and services. The survey should be performed by a person who is thoroughly familiar with physical access standards and the operation of alcohol and drug programs. This is important because the surveyor should be able to identify and prioritize physical barriers to program access—not just identify ADAAG or Title 24 violations in general. A surveyor who understands the nature of a program can suggest cost-efficient solutions and alternatives to physical barrier removal. The Department of Justice also advises that this process should include consultation with individuals with disabilities or

organizations representing them. They may provide useful guidance identifying the most significant barriers to remove and the most efficient means of removing them. "A serious effort at self-assessment and consultation can diminish the threat of litigation and save resources by identifying the most efficient means of providing required access."[27]

Depending upon the program, barriers that prevent access to toilet and shower facilities, bedrooms, meeting areas, dining rooms, counseling offices, medical offices, and other essential program areas would be considered programmatic barriers. Programmatic barriers often also include stairs, narrow doorways, and lack of accessible features such as disabled-accessible parking spaces, toilet stalls, sinks, showers, pay telephones, and drinking fountains.

Certain architectural features such as bathrooms and meeting rooms must be made accessible. In many cases, however, alternative measures to barrier removal can narrow the scope of renovation required while providing equivalent program access for persons with disabilities.

> EXAMPLE: A program normally performs intake off-site at an inaccessible facility. An alternative to a costly renovation project would be to conduct intake of applicants with disabilities at an alternate accessible location.

This may sound very complicated on paper, but in most cases barrier removal is a common sense issue. Becoming familiar with the ADA Title III physical access requirements is an important first step toward undertaking a barrier removal project.

The following readily achievable barrier removal guidelines are quoted directly from the *Department of Justice ADA Title III Technical Assistance Manual* unless otherwise specified in the References section of this publication.

What Is an Architectural Barrier?

Architectural barriers are physical elements of a facility that impede access by people with disabilities. These barriers include more than obvious impediments such as steps and curbs that prevent access by people who use wheelchairs.

In many facilities, telephones, drinking fountains, mirrors, and paper towel dispensers are mounted at a height that makes them inaccessible to people using wheelchairs. Conventional doorknobs and operating controls may impede access by people who have limited manual dexterity. Deep-pile carpeting on floors and unpaved exterior ground surfaces often are a barrier to access by people who use wheelchairs and people who use other mobility aids, such as crutches. Impediments caused by the location of temporary or movable structures, such as furniture, equipment, and display racks, are also considered architectural barriers.[28]

What Is a Facility?

The term "facility" includes all or any part of a building, structure, equipment, vehicle, site (including roads, walks, passageways, and parking lots), or other real or personal property. Both permanent and temporary facilities are subject to the barrier removal requirements."[29]

What Architectural Standards Apply to Alcohol and Drug Programs in California?

Measures taken to remove barriers should comply with the Department of Justice's ADA Accessibility Guidelines (ADAAG) and California Accessibility Regulations (Title 24). Deviations from ADAAG and Title 24 are acceptable only when full compliance with those requirements is not readily achievable. In such cases, barrier removal measures may be taken that do not fully comply with the standards, so long as the measures do not pose a significant

risk to the health or safety of individuals with disabilities or others.[30]

How Does the Readily Achievable Standard Relate to the ADA Standards for New Constructions And Alterations?

The ADA establishes different standards for architectural barrier removal from existing facilities than from facilities undergoing a new construction or alteration project. In existing facilities, where retrofitting may be expensive, the requirement to provide access is less stringent than it is in new construction and alterations, where accessibility can be incorporated in the initial stages of design and construction, often without a significant increase in cost.

The readily achievable standard also requires a lesser degree of effort on the part of alcohol and drug programs than the "undue burden" limitation on the auxiliary aids requirements of the ADA. In that sense, it can be characterized as a lower standard.[31] Also see section titled "Limitations and alternatives" on page [136].

What Barriers Are Readily Achievable to Remove?

There is no definitive answer to this question, because determinations as to which barriers can be removed without much difficulty or expense must be made on a case-by-case basis.

The Department of Justice's regulation contains a list of 20 examples of modifications that may be readily achievable:

1. Installing ramps;
2. Making curb cuts in sidewalks and entrances;
3. Repositioning shelves;
4. Rearranging tables, chairs, vending machines, display racks, and other furniture;
5. Repositioning telephones;
6. Adding raised markings on elevator control buttons;
7. Installing flashing alarm lights;
8. Widening doors;
9. Installing offset hinges to widen doorways;
10. Eliminating a turnstile or providing an alternative accessible path;
11. Installing accessible door hardware;
12. Rearranging toilet partitions to increase maneuvering space;
13. Insulating lavatory pipes under sinks to prevent burns;
14. Installing a raised toilet seat;
15. Installing a full-length bathroom mirror;
16. Repositioning the paper towel dispenser in a bathroom;
17. Creating designated accessible parking spaces;
18. Installing an accessible paper cup dispenser at an existing inaccessible water fountain;
19. Removing high pile, low density carpeting; or
20. Installing vehicle hand controls.

The list is intended to be illustrative. Each of these modifications will be readily achievable in many instances, but not in all. Whether or not any of these measures pertain to your program or are readily achievable is to be determined on a case-by-case basis in light of the particular circumstances presented and the factors discussed above.[32]

How Do We Determine When Barrier Removal Is Readily Achievable?

Determining if barrier removal is readily achievable is necessarily a case-by-case judgment. Factors to consider include:

- The nature and cost of the action;
- The overall financial resources of the site or sites involved; the number of persons employed at the site; the effect on expenses and resources; legitimate safety requirements necessary for safe operation, including crime prevention measures; or any other impact of the action on the operation of the site;

- The geographic separateness, and the administrative or fiscal relationship of the site or sites in question to any parent corporation or entity;
- If applicable, the overall financial resources of any parent corporation or entity; the overall size of the parent corporation or entity with respect to the number of its employees; the number type, and location of its facilities; and
- If applicable, the type of operation or operations of any parent corporation or entity, including the composition, structure, and functions of the workforce of the parent corporation or entity.

If the [alcohol and drug program] is a facility that is owned or operated by a parent entity that conducts operations at many different sites, the ... [alcohol and drug program] must consider the resources of both the local facility *and* the parent entity to determine if removal of a particular barrier is "readily achievable." The administrative and fiscal relationship between the local facility and the parent entity must also be considered in evaluating what resources are available for any particular act of barrier removal.[33]

Does the ADA Permit an Alcohol And Drug Program To Consider the Effect of a Modification on the Operation of Its Business?

Yes. The ADA permits consideration of factors other than the initial cost of the physical removal of a barrier.[34]

> EXAMPLE: A residential drug treatment program with 24 beds that has only one wheelchair accessible sleeping room is considering making another sleeping room accessible. After an appropriate access survey and consultation (see pages 139–141 for details) it is determined that the only way to make the room in question accessible would be to move the partition between it and an adjacent sleeping room, which has four beds. However, moving the partition to create accessible space would mean that the program would lose two of the four beds in the adjacent room. The effect of the net loss of two beds on the program's operation can be considered in the process of determining whether moving the partition would be readily achievable.

What Are the Priorities for Barrier Removal?

The Department [of Justice's] regulation recommends priorities for removing barriers in existing facilities. Because the resources available for barrier removal may not be adequate to remove all existing barriers at any given time, the regulation suggests a way to determine which barriers should be mitigated or eliminated first. The purpose of these priorities is to "facilitate long-term ... planning and to maximize the degree of effective access that will result from any given level of expenditure. These priorities are not mandatory.... [Programs] are free to exercise discretion in determining the most effective "mix" of barrier removal measures to undertake in their facilities."

The regulation suggests that "... [an alcohol and drug program's] first priority should be to enable individuals with disabilities to physically enter its facility." This priority on "getting through the door" recognizes that providing physical access to a facility from public sidewalks, public transportation, or parking is generally preferable to any alternative arrangements in terms of both business efficiency and the dignity of individuals with disabilities.

The next priority is for measures that provide access to those areas of ... [the facility] where services are made available to the public [clients]....

The third priority should be providing access to restrooms, if restrooms are provided for use by clients....

The fourth priority is to remove any remaining barriers to using the ... [alcohol and

drug program's] facility by, for example, [installing visual alarms, adding Brailled floor indicators to elevator panels, or] lowering telephones."[35]

If We Find Barriers That Should Be Removed, but It Is Not Readily Achievable To Undertake All of the Modifications Now, What Should We Do?

The Department [of Justice] recommends that ... [alcohol and drug programs] develop an implementation plan designed to achieve compliance with the ADA's barrier removal requirements. Such a plan, if appropriately designed and diligently executed, could serve as evidence of a good-faith effort to comply with the ADA's barrier removal requirements."[36]

What Are "Alternatives to Barrier Removal"?

When a program can demonstrate that the removal of barriers is not readily achievable, the program must make its services available through alternative methods, if such methods are readily achievable.

> EXAMPLE: A residential program that has its counseling rooms upstairs determines that it is not readily achievable to provide a ramp or elevator to these upstairs rooms. However, the program is still required to provide access to its services, if any readily achievable alternative method of delivery is available. Therefore, this program would be required to make counseling available in a downstairs room when needed.

How Can We Determine if an Alternative to Barrier Removal Is Readily Achievable?

"The factors to consider in determining if an alternative is readily achievable are the same as those that are considered in determining if barrier removal is readily achievable."[37]

If We Provide Services Through Alternative Measures, Such As Home Visits, May We Charge the Client for His Special Service?

No. "When services are provided to an individual with a disability through alternative methods because ... [a program's] facility is inaccessible, ... [the program] may not place a surcharge on the individual with a disability for the costs associated with the alternative methods."[38]

May We Consider Security Issues When Determining If an Alternative Is Readily Achievable?

Yes. "Security is a factor that may be considered when ... [an alcohol and drug program] is determining if an alternative method of delivering its ... services is readily achievable."[39]

Must Barriers Be Removed in Areas Used Only by Employees?

No. "The 'readily achievable' obligation to remove barriers in existing facilities does not extend to areas of a facility that are used exclusively by employees as work areas."[40] However, if one or more employees have disabilities which need to be accommodated through barrier removal, then barrier removal must be carried out unless it poses an "undue hardship" to the employer. This "undue hardship" standard is established by Title I of the ADA.

Are Portable Ramps Permitted?

Yes, but "only when the installation of a permanent ramp is not readily achievable. In order to promote safety, a portable ramp should have railings and a firm, stable, nonslip surface. It should also be properly secured."[41]

Do We Have to Install an Elevator?

The readily achievable standard does not require barrier removal that would necessitate

extensive restructuring or burdensome expense.[42] However, the programmatic access standard would require that program services be moved to an accessible site when needed. Therefore, small privately operated alcohol and drug programs that have limited budgets generally would not be required to remove a barrier to physical access posed by a flight of steps, if removal would require extensive ramping or an elevator.

Does the ADA Require Barrier Removal in Historic Buildings?

Yes, if it is readily achievable. However, the ADA takes into account the national interest in preserving significant historic structures. Barrier removal would not be considered readily achievable if it would threaten or destroy the historic significance of a building or facility that is eligible for listing in the National Register of Historic Places under the National Historic Preservation Act (16 U.S.C. 470, et seq.), or is designated as historic under State or local law.

EXAMPLE 1: A residential treatment program is located in a century old house that was designed by a famous architect and is listed in the National Registry of Historic Places. An architect familiar with disability access regulations has determined that ramping the front entrance would require extensive structural modifications to the front porch. The porch roof is supported by decorative columns that cannot be moved, and a ramp cannot fit between them. Therefore, ramping the front entrance would not be readily achievable. It would be readily achievable, however, to remove obstacles and broaden a pathway to a side door on the ground level which is wide enough to permit wheelchair access.

EXAMPLE 2: A nonresidential alcohol and drug counseling center is located in a private building where city founders signed a charter 150 years ago. The building itself has no architectural features that are historic. However, it is well known that the charter was signed there, and a plaque near the front entrance commemorates this fact. The entrances to this building are each up several steps. It would be readily achievable to install a ramp or a platform lift adjacent to the steps at the front entrance if the program had the resources to do so and if access to the plaque and the plaque's visibility were not obstructed by the ramp or lift.

If We Move, Do We Have an Obligation To Search for Accessible Space?

Privately operated alcohol and drug programs are not required to lease space that is accessible. However, upon leasing, the barrier removal requirements for existing facilities apply. In addition, any alterations to the space must meet the accessibility requirements for alterations.[43]

Who Has Responsibility for ADA Compliance in Leased Facilities, the Landlord or the Tenant?

Both the landlord and the tenant are public accommodations and have the full responsibility for complying with all ADA Title III requirements applicable to that place of public accommodation. The Title III regulation permits the landlord and the tenant to allocate responsibility, in the lease, for complying with particular provisions of the regulation. However, any allocation made in a lease or other contract is only effective as between the parties, and both landlord and tenant remain fully liable for compliance with all provisions of the ADA relating to that place of public accommodation.[44]

Maintaining the Accessible Features Of Your Facility

"Public accommodations [such as privately operated alcohol and drug programs] must maintain in working order equipment and features of facilities that are required to provide ready access to individuals with disabilities."

Where [alcohol and drug programs] must provide an accessible route, the route must

remain accessible and not blocked by obstacles such as furniture, filing cabinets, or potted plants. Similarly, accessible doors must be unlocked when ... [the facility] is open for business.

> EXAMPLE 1: Placing a vending machine on the accessible route to an accessible restroom would be violation if it obstructed the route.
>
> EXAMPLE 2: Placing ornamental plants in an elevator lobby may be a violation if they block the approach to the elevator call buttons or obstruct access to the elevator cars.
>
> EXAMPLE 3: Using an accessible route for storage of supplies would also be a violation, if it made the route ... [too narrow or crowded to be accessible].

BUT: An isolated instance of placement of an object on an accessible route would not be a violation, if the object is promptly removed.

Although it is recognized that mechanical failures in equipment such as elevators or automatic doors will occur from time to time, the obligation to ensure that facilities are readily accessible to and usable by individuals with disabilities would be violated if repairs are not made promptly or if improper or inadequate maintenance causes repeated and persistent failures. Inoperable or "out of service" equipment does not meet the requirements for providing access."

Final Remarks

People with disabilities need alcohol and drug abuse prevention and treatment services as much as anyone else in society. In fact, people with disabilities are at higher risk for alcohol and drug abuse problems than the general population. Your ADA implementation efforts will help to ensure that people with disabilities in your community will receive desperately needed alcohol and drug prevention and treatment services. We hope that this summary of the *US Department of Justice ADA Title III Technical Assistance Manual*, as adapted to meet the needs of alcohol and other drug service providers, has been of assistance to you. If needed, further technical assistance is available from PRTA.

Sample Alcohol and Drug Program Policies and Procedures

General Policies

Statement of nondiscrimination

It is the policy of _____ (program) to support and comply with the requirements and principles of the Americans With Disabilities Act (ADA) and to ensure that, to the maximum extent practicable, persons with disabilities are afforded equal access to the facilities, programs, and services of _____ (program).

_____ (program) has assigned overall responsibility for ensuring equal opportunity and nondiscrimination in the provision of services and on-going compliance with the ADA to _____ (name) _____ (title).

The following notice will be included in all contracts we enter into with other entities to provide services to our program and clients:

Federal law requires that you comply with the Americans With Disabilities Act and _____ (program) requires you to adhere to our policy of nondiscrimination when providing services to _____ (program) and our clients.

Prevention and outreach

The prevention and outreach materials produced by _____ (program) will be available in alternative format (such as large print, cassette tape or computer disk) upon request.

A representative number of the outreach events and prevention/educational presentations conducted by _____ (program) will be held in wheelchair accessible locations. Upon advance request, sign language interpreters will be available at outreach/educational presentations when feasible.

Recruitment and advertising

All written program advertising materials will be available in alternative formats upon request. All advertisements will contain a statement that _____ (program) does not discriminate against people with disabilities. Whenever possible, information will be circulated to organizations and agencies that serve people with disabilities.

Benefits and services

_____ (program) will ensure that persons with disabilities are provided maximum opportunity to participate in and benefit from all our programs, services, and activities. Moreover, it is our goal that such participation will be in an equally effective manner as non-disabled people.

Providing accommodations

_____ (program) will accommodate the known disabilities of otherwise qualified program applicants and participants. When a prospective client or program participant identifies having a disability that requires accommodation, program staff will discuss possible disability accommodations with that person.

Whenever possible, preference will be given to the disability accommodation that is the individual's first choice. If that accommodation cannot be provided, program staff will suggest one or more alternative accommodations that could be provided to ensure the individual's full participation in the

program. If necessary, staff will seek the assistance of disability service providers in order to develop effective accommodations.

Medications

Program participants will not be excluded from our program because they take appropriately prescribed medications to maintain their health. Program staff will arrange for the secure storage of appropriately prescribed medication. All medications will be locked in _____. All prescribed medications will be taken as outlined on the bottle and logged in the medication record book.

Application forms and intake questions

The criteria for admission into this program shall not exclude or restrict the participation of people with disabilities. During intake, staff shall not ask questions about disability, *unless* this information is part of medical history taking and medical history taking is required of all prospective clients. If a prospective client self-identifies as having a disability, intake staff may ask questions about how to accommodate the person's disability needs.

Risk identification

When staff or other participants are concerned that a client or prospective client with a disability may pose a *significant risk* to others' health and safety, supervisory staff will conduct an assessment of that potential risk. This assessment will take into account factual information about the person's disability and abilities. It will exclude from consideration stereotypes, hearsay, rumors, and unwarranted fears.

Communication Access

General policy

_____(program) will ensure equally effective communication and participation in our services for people with disabilities.

Auxiliary aids and services for people with disabilities (including people who are deaf or hard of hearing, blind or vision impaired, speech impaired, learning disabled, and cognitively disabled) will be provided in all phases of participation in our program. These will be provided unless the Program Director determines that a specifically requested auxiliary aid or service would fundamentally alter the nature of our program or result in an undue financial burden.

The individual with the disability will be provided an opportunity to request the auxiliary aid or service of their choice. If it is not feasible for _____(program) to provide the requested aid or service, the Program Director will suggest other effective aids or services which _____(program) can provide to accommodate the individual's needs.

Telecommunication Device for the Deaf (TDD) (For programs that have TDDs)

_____ has a TDD and at least one staff person per shift is trained in how to use it. Our TDD phone line, if separate, is included in our local telephone directory and in all our advertising materials. Program participants will, as needed, have access to and use of this TDD.

California Relay Service

At least one staff person per shift is trained in how to use the California Relay Service. This person will train other staff in how to use the California Relay Service if necessary.

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Interpreter services

Upon being provided with reasonable prior notice of need _____ (program) will, to the maximum extent feasible, provide interpreters for program services and/or activities by contacting _____ in our community.

We have the goal of allocating funds in our budget for providing interpreter services when they are needed.

Written materials

All written program materials distributed to clients will, upon reasonable prior notice of need, be made available in alternative formats (large print, cassette tape, Braille, computer disk, modified English).

Emergency Communications and Evacuation

Our fire safety and emergency warning systems are configured and maintained in compliance with applicable state and local building codes and regulations. This includes provision of visual alarms and/or bed shakers to alert the deaf and hard-of-hearing to fire and other emergency situations.

The emergency evacuation procedure is as follows:

- When the fire alarm rings, clients leave the building and assemble _____ (location).
- Roll-call is taken and the sign-out book is checked to account for each resident/participant.
- The person on duty will assist any disabled person from the building. Other residents/participants will assist if necessary.

Emergency drills are carried out on a regular basis.

Information on emergency evacuation procedures will, as appropriate, be provided to clients verbally, in written form, or in alternative format as earlier described.

Staff and other residents will receive training from each resident/participant with a disability in the best way to assist him/her in an evacuation.

The person(s) responsible for coordination training for emergency evacuation in our program are _____.

Transportation

Whenever transportation is provided as a component of program services, _____ (program) will provided appropriate accessible transportation to residents/participants with disabilities.

- _____ (a number) of the vehicles we use for transporting clients are accessible to people who use wheelchairs.

  or

- We have no accessible vehicle but contract with _____ (name of service) to provide accessible transportation services when needed.

Extracurricular Activities

Whenever extracurricular activities, such as 12-Step meetings and social, educational and recreational events, are provided or offered as a component of program services, _____ (program) will ensure that these or other equivalent activities are accessible to persons with disabilities.

Completion and Followup

Reasonable modifications will be made to completion and followup procedures for participants with disabilities. Referrals will include accessible 12-Step meetings, group and family counseling, educational and vocational services, recreational programs, and other community resources appropriate for the individual participant.

Grievance Procedures

All participants will be informed of their right to express grievances through an effective grievance procedure. It may be used by anyone who wishes to file a complaint alleging discrimination on the basis of disability in the provision of services, activities, programs or benefits.

The complaint should be made in writing and contain information about the alleged discrimination such as name, address, phone number of complainant and location, date, and description of the problem.

Alternative means of filing complaints, such as personal interviews or tape recording of the complaint, will be made available to persons with disabilities upon request.

The complaint should be submitted to _____ (name), _____ (title) as soon as possible, but no later than 60 calendar days after the alleged violation.

Within 7 calendar days after receipt of the complaint, _____ (name/title) will meet with the complainant to discuss the complaint and possible resolutions.

Within 7 calendar days after the meeting _____ (name/title) will respond in writing, or other format accessible to the complainant and offer options for resolution.

If the client is not satisfied, he or she may appeal the matter to _____ (name/title/agency/address/phone) who will adhere to steps "c" and "d" above.

If the client is still not satisfied, he or she may appeal to the County ADA Coordinator, _____ (name/title/agency/address/phone).

References

[1] See "Individuals with disabilities - General." The ADA, Title III TAM – 2.1000, 8.

[2] See *The Americans With Disabilities Act Handbook*, Equal Employment Opportunity Commission and U.S. Department of Justice (Washington, DC: U.S. Government Printing Office, 1991), Preamble, 1.

[3] From "Drug addition as an impairment," *The Americans With Disabilities Act Title III Technical Assistance Manual* (Washington, DC: Department of Justice, Civil Rights Division, Office on the Americans With Disabilities Act), III-2.3000, 9.

[4] See *The Americans With Disabilities Act Title III Fact Sheet* (Washington, DC: U.S. Department of Justice, Civil Rights Division, Office on the Americans With Disabilities Act).

[5] From *Strategizer 9. Coalitions Address Americans With Disabilities*, Resource Center on Substance Abuse Prevention and Disability (Washington, DC: Community Anti-Drug Coalitions of America), 3-1, 4.

[6] See *Alcohol and Other Drug Abuse Prevention for Persons With Disabilities* (Washington, DC: Resource Center on Substance Abuse Prevention and Disability, 1991), 1.

[7] From "Specialties," *The Americans With Disabilities Act Title III Technical Assistance Manual* (Washington, DC: U.S. Department of Justice, Civil Rights Division, Office on the Americans With Disabilities Act), III-4.2200, 22-23.

[8] From "Drug addiction as an impairment," *The Americans With Disabilities Act Title III Technical Assistance Manual, III-2.3000, 9.*

From "Drug addition as an impairment," The ADA Title III TAM, III-2.3000, 9.

[9] Ibid.

[10] From "Illegal use of drugs," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-3.9000, 18.

[11] Ibid.

[12] From "Direct threat," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-3.8000, 17-18.

[13] See "Separate benefit/integrated setting," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-3.4000, 14, and III-3.4200, 14.

[14] See "Separate benefit/integrated setting" and "Modifications in the regular program," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-3.4000 and III 3.4300, 14-15.

[15] See "Personal services and devices," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III 4.2600, 24.

[16] See "Surcharges," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4.1400, 22.

[17] From "Smoking," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-3.10000, 18.

[18] An analogous situation is described in "Service animals," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4.2300, 23.

[19] See "Retaliation or coercion," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-3.6000, 16.

[20] See "Effective communications," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4.3200, 25.

[21] From "Examples of auxiliary aids and services," quoted from *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4.3300, 26-27.

[22] See "Effective communications," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4.3200, 26.

[23] From "Limitations and alternatives," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4.3600, 27

[24] From Ibid, 28.

[23] See "Effective communications," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4.3200, 26.

[24] From "Outgoing calls by customers, clients, patients, or participants," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4.3420, 27.

[25] Ibid, 34.

[26] From "Removal of barriers—General," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4100, 28-29.

[27] Ibid.

[28] See "Standards to apply," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4.4300, 32.

[29] See "Readily achievable barrier removal," *The Americans With Disabilities Title III Technical Assistance Manual*, III-4.4200, 29.

[30] Ibid, 30-31.

[31] Ibid, 29-30.

[32] Ibid, 32.

[33] See "Priorities for barrier removal," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4.4500, 34.

[34] Ibid, 34-35.

[35] From "Alternatives to barrier removal—General," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4.5100, 38.

[36] Ibid.

[37] Ibid.

[38] From "Priorities for barrier removal," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4.4500, 34.

[39] From "Standards to apply," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4.4300, 33.

[40] See "Readily achievable barrier removal," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-4.4200, 31.

[41] Ibid.

[42] From "Public accommodations," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-1.2000, 3.

[43] From "Maintenance of accessible features," *The Americans With Disabilities Act Title III Technical Assistance Manual*, III-3.7000, 17.

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